



New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

Hepatitis C Medications

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: - -

GENDER: Male Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: - -

FAX NUMBER: - -

SECTION III: CLINICAL HISTORY

- Is the prescriber a gastroenterologist, hepatologist, or infectious disease specialist, or has one of these specialists been consulted in this case? Yes No
If NO to question 1, has the prescriber completed continuing education related to Hepatitis C? Yes No
- Does the patient have a diagnosis of Hepatitis C? Yes No
- Document patient's genotype. _____
- Does the patient have a diagnosis of HIV or cirrhosis? Yes No
- Has the patient been tested for Hepatitis B (using HbsAg and anti-HBc)? Yes No
- Is the patient being treated for substance or alcohol use disorder? Yes No
- Has the patient tried/failed a protease inhibitor or Sovaldi in the past? Yes No
- Will the patient be on concurrent proton pump inhibitor? Yes No
- Will the patient be on concurrent therapy with Ribavirin and/or Peginterferon? Yes No

REQUEST FOR SOVALDI ONLY (COMPLETE THE FOLLOWING SECTION)

- Is the patient intolerant to Interferon? Yes No
If YES, reason for intolerance: _____
- Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.

If you are requesting a Non-Preferred product, proceed to Section IV.



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PATIENT FIRST NAME:

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SECTION IV: NON-PREFERRED DRUG APPROVAL CRITERIA

Chapter 188 of the Laws of 2004 requires that Medicaid only cover non-preferred drugs upon a finding of medical necessity by the prescribing physician. Chapter 188 requires that you base your determination of medical necessity on the following criteria.

- Allergic reaction. Describe reaction:

- Drug-to-drug interaction. Describe reaction:

- Previous episode of an unacceptable side effect or therapeutic failure. Provide clinical information:

- Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. Provide clinical information:

- Age specific indications. Provide patient age and explain:

- Unique clinical indication supported by FDA approval or peer reviewed literature. Explain and provide a reference:

- Unacceptable clinical risk associated with therapeutic change. Please explain:

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ DATE: _____