Staywell℠
A WellCare Company

PRIOR AUTHORIZATION REQUEST FORM FOR HEPATITIS C TREATMENT

Instructions: Please complete ALL FIELDS and FAX COMPLETED FORM TO 1-866-825-2884.

Member Name		Prescriber FULL Name/Specialty
Staywell Member ID #	Date of Birth	Prescriber NPI
Member's Telephone Number		Office Address
Diagnosis of Chronic Hepatits C ☐ Yes ☐ No		
Genotype:		Office Phone #
Does the patient have decompensated liver disease? ☐ Yes ☐ No		Office Fax #

REQUESTED MEDICATION(S)

Drug Name	Drug Strength	Drug Dosage Form	Length of Treatment

New start or a continuation of therapy? ☐ New start ☐ Continuation Start Date:_____

Previous therapies used to treat hepatitis C:

Drug & Dose Used	Start Date	Stop Date	Therapeutic Outcome

****REQUIRED DOCUMENTATION – Please submit all required clinical notes/lab reports in reference to this request.****

- If awaiting liver transplant, is the patient suitable for transplant per Milan criteria? ☐ Yes ☐ No
- **Substance or Alcohol Use:** Patients with active substance or alcohol use disorders should be considered for therapy on a case-by-case basis, and care should be coordinated with substance use treatment specialists.

Child Pugh Score: _____ Total Serum Bilirubin: _____ Albumin: _____ INR: _____ CrCl: _____

Post liver transplant: ☐ Yes ☐ No **Ascites:** ☐ Yes ☐ No **Hepatic Encephalopathy:** ☐ Yes ☐ No

Hepatits B positive : ☐ Yes ☐ No **Human Immunodeficiency Virus (HIV) positive:** ☐ Yes ☐ No

The following document submissions are required for review:	Check off the following items that have been completed:
1) HCV-RNA viral load labs within the past 30 days 2) Urine toxology within the past 30 days 3) Fibrosis score results (Metavir, Ishak, Apri, FibroSure, FibroScan) 4) Listed name of the specialty pharmacy to fill the medication 5) Most recent complete blood count (CBC)	☐ Patient has been explained the importance of adherence and has agreed to adhere and complete the drug regimen as prescribed. ☐ Risk of hepatotoxic drugs, including acetaminophen, have been explained to the patient.

By signing below, you attest that all statements on this form are true to the best of your knowledge.

Prescriber's Signature_____**Date**_____