



**PRIOR AUTHORIZATION REQUEST FORM FOR HEPATITIS C TREATMENT**

**Instructions: Please complete ALL FIELDS and FAX COMPLETED FORM TO 1-866-388-1767**

Visit our website for Prior Authorization criteria at [www.ohanahealthplan.com](http://www.ohanahealthplan.com).

Member Name		Prescriber FULL Name/Specialty			
'Ohana ID #	Date of Birth	Prescriber NPI			
Member's Telephone Number		Office Address			
Diagnosis for use of the requested medication(s):					
Hepatitis C Genotype	Patient Weight (lbs)	Contact Name at MD Office			
Does the patient have Human Immunodeficiency Virus (HIV)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Office Phone #			
Does the patient have decompensated liver disease? <input type="checkbox"/> Yes <input type="checkbox"/> No		Office Fax #			
<b>REQUESTED MEDICATION(S)</b>					
<b>Drug Name</b>	<b>Drug Strength</b>	<b>Drug Dosage Form</b>	<b>Length of Treatment</b>		
New start or a continuation of therapy? <input type="checkbox"/> New start <input type="checkbox"/> Continuation      Start Date: _____					
<b>Pertinent past or present therapies (including OTCs and non-pharmacological):</b> (MUST attach comprehensive list or complete form)					
<b>Drug &amp; Dose Used</b>	<b>Route</b>	<b>Frequency</b>	<b>Start Date</b>	<b>Stop Date</b>	<b>Therapeutic Outcome</b>
<b>**REQUIRED DOCUMENTATION – Please submit all required clinical notes/lab reports in reference to this request.**</b>					
If awaiting liver transplant, is the patient suitable for transplant per Milan criteria? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Side effects and length of therapy have been explained to member and documented by physician. The member understands the importance of adherence and completion of the medication protocol. <input type="checkbox"/> Yes <input type="checkbox"/> No					
Child Pugh Score: _____ Platelet count: _____ Total Serum Bilirubin: _____ Albumin: _____					
INR: _____ Ascites: <input type="checkbox"/> Yes <input type="checkbox"/> No      Hepatic Encephalopathy: <input type="checkbox"/> Yes <input type="checkbox"/> No      CrCl: _____					
Liver Biopsy: <input type="checkbox"/> Metavir Score: _____ <input type="checkbox"/> Ishak Score: _____ <input type="checkbox"/> Other _____					
<b>BASELINE LAB DATA (REQUIRED FOR APPROVAL)</b>					
Viral Load: _____ IU/mL      AST: _____      ALT: _____					

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

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_