pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

HEPATITIS C AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Hepatitis C Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	total # pages: _____	Prescriber name:	
Office contact name/phone:		State license #:	NPI:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Requested drug #1:	Directions:	Qty:	Refills:
Requested drug #2:	Directions:	Qty:	Refills:

SUBMIT DOCUMENTATION from the medical record for all items below.

Genotype:	Date of testing:	Baseline viral load:	Date of testing:

Beneficiary's complete medication list:		
Does the beneficiary have results of RAS (resistance-associated substitutions) testing?	☐Yes – *Submit documentation.*	☐No
Does the beneficiary have results of recent kidney function tests and Metavir fibrosis score?	☐Yes – *Submit documentation.*	☐No
Does the beneficiary have results of HIV screening (HIV Ag/Ab)?	☐Yes – *Submit documentation.*	☐No
If confirmed positive by HIV-1/HIV-2 antibody differentiation immunoassay, is the beneficiary being treated for HIV infection?	☐Yes ☐No	*Submit documentation of HIV treatment or rationale for not treating.*
Does the beneficiary have documentation of receipt of the hepatitis B vaccination series or results of hepatitis B screening (HBsAg, anti-HBs, and anti-HBc)?	☐Yes ☐No	*Submit documentation of vaccination or screening results.*
If positive for hepatitis B sAg (HBsAg), does the beneficiary have results of quantitative HBV DNA testing?	☐Yes ☐No	*Submit documentation of test results. If positive, submit plan for hep B treatment. If negative, submit plan for hep B vaccination.*
Was the beneficiary previously treated for hepatitis C?	☐Yes ☐No	*Submit documentation of previous regimen, dates, lab work, and treatment outcome. Include results of NS5A RAS screening for all DAA treatment failures.*
Does the beneficiary have documented commitment to adherence with the planned course of treatment and mutual monitoring by the prescriber and the Department?	☐Yes ☐No	**Direct contact information for office hepatitis C contact (REQUIRED):** Name: _____ Phone #: _____ Email: _____
Will the beneficiary be taking ribavirin?	☐Yes – *Submit documentation of CBC with differential (within past 3 months) and, if female, a recent negative pregnancy test and contraceptive measures that will be used.*	☐No
For requests for NON-PREFERRED agents: Has the beneficiary tried and failed or have a contraindication or intolerance to the preferred Hepatitis C Agents? *Refer to https://papdl.com/preferred-drug-list for the list of preferred and non-preferred Hepatitis C Agents.*	☐Yes ☐No	*Submit documentation.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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