

Fax Requests To: (866) 845-7267 Request By Phone: (877) 813-5595

Hepatitis C Coverage Determination

(FOR PROVIDER USE ONLY)

МЕМВ	ER INFORMATION RE	QUIRED (Please Write L	Legibly)			
Customer Name:		Customer ID:	Customer ID:			
Customer DOB:		Customer Address:	Customer Address:			
Phone (Home):		Phone (Cell):				
		DN REQUIRED (Please)				
License Number: DEA Number:			NPI Number:			
Provider Name:		Provider Address:	Provider Address:			
Provider Phone:		Provider Fax:	Provider Fax:			
Provider Specialty:		Office Contact Name:				
DRUG & PRES	CRIPTION INFORMAT	ION REQUIRED (Pleas	se Write Legibly)			
Drug Name:		Dosage:	Dosage:			
Frequency:		Quantity:	Refills:			
Do Not Substitute-Dispense As Written		Please check whether this is a new medication or therapy continuation				
		□ New Medication	tion Continuation			
			If you have checked "Continuation",			
		Provide S	Provide Start Date>			
	8F1 F					
	3ELE(CT DIAGNOSIS				
Hepatitis C- Naïve		Follicular Lyn	Follicular Lymphoma			
Hepatitis C-Relapsed or	Previous Failure	Hairy Cell Let	Hairy Cell Leukemia			
Hepatitis B (Chronic)		Malignant M	Malignant Melanoma			
Condylomate Acuminata		AIDS related	AIDS related KS			



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Is the Cirrhosis: Compensated Decompensated Has the patient received liver transplant? YES N Is this request for an inpatient that is awaiting discharge? YES N Continuation: Has a positive virologic response been demonstrated with a negative HCV RNA? YES N	at Canatima:						
Please provide member's HCV-RNA levels: Does the customer have cirrhosis? PYES Is the Cirrhosis: Compensated Has the patient received liver transplant? YES Is this request for an inpatient that is awaiting discharge? YES Continuation: PYES Has a positive virologic response been demonstrated with a negative HCV RNA? YES Has a positive virologic response been demonstrated with a log decrease in HCV RNA from baseline? YES Re-Treatment: List the drug dose, frequency and duration of therapy of the patient's previous therapy trials/failures: If the customer is unable to meet the criteria required for the requested medication, please provide a clinical explanation as to we exception should be made: Drug Supplied By: Pharmacy Physician's Supply Other:	si Genotype:						
Does the customer have cirrhosis? YES N Is the Cirrhosis: Compensated Decompensated Has the patient received liver transplant? YES N Is this request for an inpatient that is awaiting discharge? YES N Continuation:	st weight in Kg:						
Is the Cirrhosis: Compensated Has the patient received liver transplant? YES Is this request for an inpatient that is awaiting discharge? YES Continuation: Has a positive virologic response been demonstrated with a negative HCV RNA? YES N Has a positive virologic response been demonstrated with a log decrease in HCV RNA from baseline? YES N Re-Treatment: List the drug dose, frequency and duration of therapy of the patient's previous therapy trials/failures: If the customer is unable to meet the criteria required for the requested medication, please provide a clinical explanation as to we exception should be made: Mainistration Site: Patient's home Physician's office Long Term Care Other:	ease provide member's	HCV-RNA levels:					
Has the patient received liver transplant? YES N Is this request for an inpatient that is awaiting discharge? YES N Continuation:	oes the customer have	cirrhosis?			□ YES	□ NO	
Is this request for an inpatient that is awaiting discharge? Is this request for an inpatient that is awaiting discharge? YES N Continuation: Has a positive virologic response been demonstrated with a log decrease in HCV RNA? YES N Has a positive virologic response been demonstrated with a log decrease in HCV RNA from baseline? YES N Re-Treatment:	Is the Cirrho	sis: 🗆 Compensate	d 🛛 Decompensated				
Continuation: Has a positive virologic response been demonstrated with a negative HCV RNA? YES N Has a positive virologic response been demonstrated with a log decrease in HCV RNA from baseline? YES N Re-Treatment:	as the patient received	□ YES	□ NO				
Has a positive virologic response been demonstrated with a negative HCV RNA? YES N Has a positive virologic response been demonstrated with a log decrease in HCV RNA from baseline? YES N Re-Treatment: List the drug dose, frequency and duration of therapy of the patient's previous therapy trials/failures: YES N If the customer is unable to meet the criteria required for the requested medication, please provide a clinical explanation as to we exception should be made:	Is this request for an inpatient that is awaiting discharge?					□ NO	
Has a positive virologic response been demonstrated with a log decrease in HCV RNA from baseline? YES N Re-Treatment: List the drug dose, frequency and duration of therapy of the patient's previous therapy trials/failures: If the customer is unable to meet the criteria required for the requested medication, please provide a clinical explanation as to we exception should be made: If the customer is unable to meet the criteria required for the requested medication, please provide a clinical explanation as to we exception should be made: Administration Site: Patient's home Home infusion Skilled nursing Physician's office Long Term Care Other: Other: Drug Supplied By: Pharmacy Physician's Supply Other: Additional information must be submitted to support medical necessity Request for expedited review (24 hours). By checking this box, I certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the Customer's ability to regain maximum function	ontinuation:						
Re-Treatment: List the drug dose, frequency and duration of therapy of the patient's previous therapy trials/failures: If the customer is unable to meet the criteria required for the requested medication, please provide a clinical explanation as to we exception should be made: If the customer is unable to meet the criteria required for the requested medication, please provide a clinical explanation as to we exception should be made: Administration Site: Patient's home Home infusion Skilled nursing Physician's office Long Term Care Orug Supplied By: Pharmacy Physician's Supply Other: Additional information must be submitted to support medical necessity Request for expedited review [24 hours]. By checking this box, I certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the Customer or the Customer's ability to regain maximum function	Has a positive virologic response been demonstrated with a negative HCV RNA?					□ NO	
List the drug dose, frequency and duration of therapy of the patient's previous therapy trials/failures:	Has a positive virologic response been demonstrated with a log decrease in HCV RNA from baseline?					□ NO	
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Physician's office Long Term Care Other:			Quirea for the requested mean	cation, please provide a d		on as to wny an	
Drug Supplied By: Pharmacy Physician's Supply Other:	Iministration Site:	Patient's home	☐ Home infusion	Skilled nursing			
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standard review time frame may seriously jeopardize the life or health of the Customer or the Customer's ability to regain maximum functio	rug Supplied By:		_				
Provider Signature: Date:		Pharmacy	Physician's Supply				
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