

Hepatitis C Coverage Determination

(FOR PROVIDER USE ONLY)

MEMBER INFORMATION REQUIRED (Please Write Legibly)	
Customer Name:	Customer ID:
Customer DOB:	Customer Address:
Phone (Home):	Phone (Cell):

PROVIDER INFORMATION REQUIRED (Please Write Legibly)		
License Number:	DEA Number:	NPI Number:
Provider Name:	Provider Address:	
Provider Phone:	Provider Fax:	
Provider Specialty:	Office Contact Name:	

DRUG & PRESCRIPTION INFORMATION REQUIRED (Please Write Legibly)	
Drug Name: _____	Dosage: _____
Frequency: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Do Not Substitute-Dispense As Written	
<i>Please check whether this is a new medication or therapy continuation</i>	
<input type="checkbox"/> New Medication	
<input type="checkbox"/> Continuation	
If you have checked "Continuation", Provide Start Date-----> _____	

SELECT DIAGNOSIS	
<input type="checkbox"/> Hepatitis C- Naïve <input type="checkbox"/> Hepatitis C-Relapsed or Previous Failure <input type="checkbox"/> Hepatitis B (Chronic) <input type="checkbox"/> Condylomate Acuminata	<input type="checkbox"/> Follicular Lymphoma <input type="checkbox"/> Hairy Cell Leukemia <input type="checkbox"/> Malignant Melanoma <input type="checkbox"/> AIDS related KS

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Other Questions:

List Genotype: _____

List weight in Kg: _____

Please provide member's HCV-RNA levels: _____

Does the customer have cirrhosis? YES NO

Is the Cirrhosis: Compensated Decompensated

Has the patient received liver transplant? YES NO

Is this request for an inpatient that is awaiting discharge? YES NO

Continuation:

Has a positive virologic response been demonstrated with a negative HCV RNA? YES NO

Has a positive virologic response been demonstrated with a log decrease in HCV RNA from baseline? YES NO

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 why an exception should be made:

Administration Site: Patient's home Home infusion Skilled nursing
 Physician's office Long Term Care 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 or the Customer's ability to regain maximum function

Provider Signature:

Date:

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