RI AIDS DRUG ASSISTANCE PROGRAM (ADAP) PRIOR AUTHORIZATION REQUEST FORM

Executive Office of Health & Human Services
RETURN PA BY FAX (401) 784-3889 ATTN: PHARMACIST
301 Metro Center Blvd., 3rd Floor • Warwick, RI 02886 • PROVIDER HELP DESK (401) 784-8100

PATIENT NAME: ___________________________ DOB: __________ ADAP ID NUMBER: _______________________

PRESCRIBER NAME: ___________________________ NPI #: ______________________ OFFICE FAX NUMBER: (______) _____ - _______

CLINICAL INFORMATION:

a. DATE INITIAL DIAGNOSIS ___________________________ INITIAL VIRAL LOAD __________________ DATE OF INITIAL VL REPORT _______________________

b. HEPATITIS C GENOTYPE ___________________________

c. CURRENT QUANTITATIVE VIRAL LOAD (VL) ______________ AND CURRENT DATE OF VL REPORT _______________________

d. IS CIRRHOSIS PRESENT? ______ YES ______ NO; IF YES, _____ COMPENSATED _____ DECOMPENSATED

e. PROVIDE ANY OTHER RELEVANT CLINICAL INFORMATION:

f. WHAT STAGE OF LIVER FIBROSIS IS THE PATIENT? ______ 0 ______ 1 ______ 2 ______ 3 ______ 4

g. LIVER FIBROSIS CONFIRMED BY (PLEASE INDICATE QUANTITATIVE VALUE):

<table>
<thead>
<tr>
<th>INDICATE QUANTITATIVE VALUE(S)</th>
<th>HCV &amp; HIV CO-INFECTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAGE CONFIRMED BY:</td>
<td>STAGE</td>
</tr>
<tr>
<td>AST/PLATELET RATIO INDEX</td>
<td></td>
</tr>
<tr>
<td>FIBROSCAN</td>
<td></td>
</tr>
<tr>
<td>FIBROTEST</td>
<td></td>
</tr>
<tr>
<td>IMAGING STUDY (PLEASE SPECIFY &amp; ATTACH REPORT)</td>
<td></td>
</tr>
<tr>
<td>LIVER BIOPSY RESULT</td>
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</tbody>
</table>

g. IS THERE EVIDENCE OF HEPATOCellular CARCINOMA? ______ YES ______ NO

h. IS PATIENT ON A TRANSPLANT LIST? ______ YES ______ NO

i. HISTORY OF PRIOR THERAPY FOR HEPATITIS C? ______ YES ______ NO

a. DATE(S) OF THERAPY: ___________________________

b. TREATMENT REGIMEN USED:

j. IS A SIGNED COPY OF A PATIENT HEPATITIS-C CONTRACT IN THE PATIENT’S MEDICAL RECORD? ______ YES ______ NO

MEDICATION(S) REQUEST(ED):

1. MEDICATION: ___________________________ DOSE: ___________________________ WEEKS: __________________

2. MEDICATION: ___________________________ DOSE: ___________________________ WEEKS: __________________

PRESCRIBER ATTESTATION AND SIGNATURE ___________________________ DATE __________________

BY SIGNATURE, THE PRESCRIBER CONFIRMS S/HE IS AUTHORIZED TO PRESCRIBE THIS MEDICATION, THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY CLIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST BY EOHHS/ADAP.

FOR STATE USE ONLY:

APPROVAL: ______ YES ______ NO PRIOR AUTHORIZATION #: _________________________ EFFECTIVE DATES - FROM: __________ To __________

03.17