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):

INDICATE QUANTITATIVE VALUE(S)	***HCV & HIV CO-INFECTED***	
STAGE CONFIRMED BY:	***STAGE***	***REPORT DATE***
AST/PLATELET RATIO INDEX		
FIBROSCAN		
FIBROTEST		
IMAGING STUDY (PLEASE SPECIFY & ATTACH REPORT)		
LIVER BIOPSY RESULT		

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 _____