



Executive Office of Health & Human Services
MEDICAID FEE FOR SERVICE (FFS) PRIOR AUTHORIZATION REQUEST FORM
Hewlett Packard Enterprise ATTN: PHARMACIST
301 Metro Center Blvd., 3rd Floor • Warwick, RI 02886 • FAX (401) 784-3889 • PH (401) 784-8100

PATIENT NAME: _____ DOB: _____ MEDICAID ID NUMBER: _____

PRESCRIBER NAME: _____ NPI #: _____ OFFICE FAX NUMBER: () _____

CLINICAL INFORMATION:

a. HEPATITIS C GENOTYPE _____ QUANTITATIVE VIRAL LOAD _____ DATE OF REPORT _____

b. CURRENT CLINICAL STATUS INCLUDING COMPENSATED/DECOMPENSATED LIVER DISEASE:

c. IS PATIENT CO-INFECTED WITH HIV? _____ YES _____ NO

d. WHAT STAGE OF LIVER DISEASE IS THE PATIENT? _____ 0 _____ 1 _____ 2 _____ 3 _____ 4

e. DISEASE CONFIRMED BY (PLEASE INDICATE QUANTITATIVE VALUE):

| INDICATE QUANTITATIVE VALUE(S) | HCV & HIV CO-INFECTED | | NON CO-INFECTED | |
|---------------------------------------------------|-----------------------|-------------|-----------------|-------------|
| | STAGE 2 OR GREATER | REPORT DATE | STAGE 3 OR 4 | REPORT DATE |
| AST/PLATELET RATIO INDEX | | | | |
| FIBROSCAN | | | | |
| FIBROTEST | | | | |
| IMAGING STUDY (PLEASE SPECIFY & ATTACH REPORT) | | | | |
| LIVER BIOPSY RESULT | | | | |

f. HISTORY OF SIGNIFICANT ALCOHOL OR INTRAVENOUS DRUG USE DISORDER: _____ YES _____ NO

a. IF YES, HAS PATIENT BEEN DRUG FREE FOR THE PAST SIX (6) MONTHS? _____ YES _____ NO

b. **OR**, IS PATIENT PARTICIPATING IN AN ACTIVE MONITORING/THERAPEUTIC PROGRAM? _____ YES _____ NO

g. 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 PATIENT INTERFERON ELIGIBLE? _____ YES _____ NO

k. IS A SIGNED COPY OF A **PATIENT HEPATITIS-C CONTRACT** IN THE PATIENT'S MEDICAL RECORD? _____ YES _____ NO

MEDICATION REQUEST:

MEDICATION AND DOSE REQUESTED: _____

a. DURATION OF TREATMENT: _____ WEEKS

b. ADDITIONAL HEPATITIS C MEDICATIONS PLANNED: _____

PRESCRIBER ATTESTATION AND SIGNATURE _____ DATE _____

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

FOR STATE USE ONLY:

APPROVAL: _____ YES _____ NO PRIOR AUTHORIZATION #: _____ EFFECTIVE DATES: FROM: _____ TO _____