sunshine health

MEDICATION PRIOR AUTHORIZATION REQUEST FORM
FAX this completed form to 1-833-546-1507
OR Mail request to: Pharmacy Services Prior Authorization Dept.
5 River Park Place East, Suite 210 | Fresno, CA 93720

Reset Form | Print Form

Pharmacy Services will respond via fax or phone within 24 hours of receipt of all necessary information, expect during weekends and holidays. For immediate response on weekends and holidays, NurseWise will answer your call.

HEPATITIS C AGENTS

Note: Form must be completed in full.
An incomplete form may be returned.

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY) / /

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber's Phone Number - -

Prescriber's Fax Number - -

Preferred with automated prior authorization (PA): Mavyret® and sofosbuvir/velpatasvir (generic Epclusa®)

Preferred with clinical PA: Vosevi® (retreatment recipients)

(If prescribing non-preferred alternatives, please provide documentation of medical reason(s) why the patient is unable to take a preferred medication.)

What is the requested medication? *(Include strength, directions, quantity, and duration of therapy.)*

_____

Physician must submit all supporting documentation including lab results.

1. Does the recipient have chronic hepatitis C? (Submit supporting documentation.) ☐ Yes ☐ No
   If *YES*, indicate the stage of fibrosis: _____
2. What is the recipient's HCV genotype? *(attach genotype test results)* ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
3. Has the recipient been previously treated with HCV therapy? ☐ Yes ☐ No
   If *YES*, please specify date, treatment regimen, and duration: _____
   If *YES*, please document response to therapy: ☐ Null responder ☐ Partial responder ☐ Relapser
4. Does the recipient have chronic HCV with cirrhosis? *(Supporting documentation required.)* ☐ Yes ☐ No
   If cirrhosis, what type? ☐ Compensated ☐ Decompensated
5. Child-Pugh Score: (Submit supporting documentation.) ☐ A ☐ B ☐ C

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6. Has the patient recently been tested for Hepatitis B Virus infection? *(Current lab work must be included.)* ☐ Yes ☐ No

7. Does the recipient have hepatocellular carcinoma? ☐ Yes ☐ No

8. Is the recipient HIV co-infected? *(Must have documented diagnosis and must submit most recent CD4 count – within last 6 months.)* ☐ Yes ☐ No

9. Liver transplant? *(If YES, please specify date and submit supporting documentation.)*

   ☐ Awaiting liver transplant (date): _____ ☐ No ☐ Post-transplant

10. Indicate HCV RNA level: *(Must submit lab results within the past six months for baseline.)*

Treatment week	Log10	Date Measured
Pre-treatment baseline		

11. Has the recipient committed to the documented planned course of treatment, inclusive of anticipated blood tests and physician visits, during and after treatment? ☐ Yes ☐ No

12. For ribavirin therapy: If the patient is a female of childbearing potential, has a negative pregnancy test within 30 days of initiating therapy been submitted? ☐ Yes ☐ No

13. For retreatment: Is the recipient receiving substance or alcohol abuse counseling services? *(Must submit supporting documentation.)* ☐ Yes ☐ No

By signing below, the prescriber attests that all statements provided are accurate.

Prescriber's Signature: _____ **Date:** _____

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes) and the most recent copies of related labs. The provider must retain copies of all documentation for five years.