

## New Hampshire Medicaid Fee-for-Service (FFS) Program Prior Authorization/Non-Preferred Drug Approval Form

Hepatitis C Medications

	DATE OF MEDICATION REQUEST: / /																													
SE	SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED  LAST NAME:  FIRST NAME:																													
LAST NAME:								FIRST NAME:																						
MEDICAID ID NUMBER:										DATE OF BIRTH:																				
													_			_														
GE	NE	DEF	₹:		Ma	le		Fer	nale				•						'	1		•	<b></b>			•	•	•	_	
Drug Name											Strength																			
Dosing Directions									Length of Therapy																					
SE	ЕСТ	ΊO	N I	l: P	RES	CRI	BE	R IN	IFOF	RMA	ΔTI	ON																		
LAST NAME:									FIRST NAME:																					
SP	EC	IAL	TY.	:		1		ı			1		ı				NPI NUMBER:													
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PH	PHONE NUMBER:								FA	( NI	JM	BER	:		II.			ı			1									
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SE	СТ	10	ΝI	II: (	CLIN	IICA	\L F	lIST	ORY	′																				
1.							_				_		-		_	ist, o	rinfe	ctio	us	dise	ase s	peci	alist,	or l	has	one		Yes		No
	of these specialists been consulted in this case?												NI.																	
_	If <i>no</i> to question 1, has the prescriber completed continuing education related to Hepatitis C?																													
2.													☐ Yes ☐ No☐ Yes ☐ No																	
3.				-								-				•	ent ar	nd g	end	otyp	e:						_	_ res		INO
4.	D	oe:	s th	e p	atie	ent l	hav	/e a	dia	 gnos	is	of H	IIV o	r c	irrho	osis?												Yes		No
5.	Н	as '	the	pa	tier	nt be	eer	ı tes	sted	for	He	pat	itis E	3 (ı	usin	g Hbs	Ag aı	nd a	nti	-НВ	:)?							_ ] Yes		No
6.													No																	

(Form continued on next page.)

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## New Hampshire Medicaid Fee-for-Service (FFS) Program Prior Authorization/Non-Preferred Drug Approval Form

Hepatitis C Medications

DATE OF MEDICATION REQUEST: /																							
PATIENT LAST NAME:											PA	PATIENT FIRST NAME:											
SE	CTION	III: CL	INICAL	HIST	ORY	(Con	tinu	ed)		ļ				ļ.	l	l		l					
7.	Is the	re any	additio	onal i	nforr	natio	n th	at w	ould	help	in the	decis	ion-m	nakin	g pro	cess	? If						
additional space is needed, please use another page.																							
If v		rodu	esting :	Nor	n_Dro	forro	d nr	oduc	t nr	.0.00	d to Sa	action	. IV										
If you are requesting a Non-Preferred product, proceed to Section IV.  SECTION IV: NON-PREFERRED DRUG APPROVAL CRITERIA																							
			the Lav									cover	non-	prefe	rred	drug	s upo	n a fi	indin	g of r	nedic	al	
	•		presc			•					•			•		_	•			_			
		`	g criter																				
	Allergi	ic react	ion. De	scrib	e rea	actio	n:																
	Drug-	to-dru	ıg inte	ractio	n. D	escri	ibe r	eact	ion:														
	Previo	ous ep	isode c	of an	unac	cept	able	side	effe	ct or	therap	eutic	failu	re. P	rovid	le clir	nical i	nforr	matic	n:			
	Clinica	al cont	traindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug.																				
	Provid	de clini	cal info	ormat	tion:																		
	Age-s	pecific	indica	tions	. Pro	vide	patie	ent a	ge a	nd ex	plain:												
	J	•					•		J		•												
	Uniqu	ıe clini	cal ind	icatio	าก รเม	nnor	ted b	ον ΕΓ	)A ar	oprov	al or r	neer r	eviev	ved li	iterat	ure.	Fxpla	in ar	nd pro	ovide	. a		
	-	Unique clinical indication supported by FDA approval or peer reviewed literature. Explain and provide a reference:																					
	Linaco	rentah	le clini	cal ri	sk ass	cocia	ted	with	thor	anell	tic cha	οησρ	Dlaac	- AVI	nlain:								
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tha	t any	falsific	ation,	omis	sion,	or co	once	alme	ent o	f mat	erial f	act m	nay su	ıbjec	t me	to civ	vil or	crim	inal l	iabili	ty.		
PRE	ESCRIE	BER'S S	IGNAT	URE:											_ DA	TE: _					-		

**Phone**: 1-866-675-7755 **Fax**: 1-888-603-7696

