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

Hepatitis C Medications

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

SECTION III: CLINICAL HISTORY

1. Is the prescriber a gastroenterologist, hepatologist, or infectious disease specialist, or has one of these specialists been consulted in this case? ☐ Yes ☐ No
   If *no* to question 1, has the prescriber completed continuing education related to Hepatitis C? ☐ Yes ☐ No
2. Does the patient have a diagnosis of Hepatitis C? ☐ Yes ☐ No
3. Has the patient been treated for Hepatitis C in the past? ☐ Yes ☐ No
   If *yes* to question 3, document patient's prior treatment and genotype:

   _____
4. Does the patient have a diagnosis of HIV or cirrhosis? ☐ Yes ☐ No
5. Has the patient been tested for Hepatitis B (using HbsAg and anti-HBc)? ☐ Yes ☐ No
6. Is the patient being treated for substance or alcohol use disorder? ☐ Yes ☐ No
7. Has the patient tried and failed a protease inhibitor or Sovaldi in the past? ☐ Yes ☐ No
8. Will the patient be on concurrent proton pump inhibitor? ☐ Yes ☐ No
9. Will the patient be on concurrent therapy with Ribavirin and/or Peginterferon? ☐ Yes ☐ No

(Form continued on next page.)

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PATIENT LAST NAME: **PATIENT FIRST NAME:**

SECTION III: CLINICAL HISTORY *(Continued)*

REQUEST FOR SOVALDI ONLY *(COMPLETE THE FOLLOWING SECTION)*

10. Is the patient intolerant to Interferon? ☐ Yes ☐ No
    a. If *yes*, state the reason for intolerance: _____
11. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.

_____

If you are requesting a Non-Preferred product, proceed to Section IV.

SECTION IV: NON-PREFERRED DRUG APPROVAL CRITERIA

Chapter 188 of the Laws of 2004 requires that Medicaid only cover non-preferred drugs upon a finding of medical necessity by the prescribing physician. Chapter 188 requires that you base your determination of medical necessity on the following criteria.

☐ Allergic reaction. Describe reaction:

_____

☐ Drug-to-drug interaction. Describe reaction:

_____

☐ Previous episode of an unacceptable side effect or therapeutic failure. Provide clinical information:

_____

☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. Provide clinical information:

_____

☐ Age-specific indications. Provide patient age and explain:

_____

☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Explain and provide a reference:

_____

☐ Unacceptable clinical risk associated with therapeutic change. Please explain:

_____

(Form continued on next page.)

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PATIENT LAST NAME:

PATIENT FIRST NAME:

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

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

MagellanRx MANAGEMENT