MedStar Family Choice

DISTRICT OF COLUMBIA

All requests must be accompanied by MEDICAL RECORDS to support the request. MFC-DC MUST RENDER A DECISION WITHIN 24 HOURS. If MEDICAL RECORDS are INCOMPLETE, the request is subject to DENIAL.

MedStar Family Choice District of Columbia – Fax Number: 202-243-6258
Phone Inquiries: 855-798-4244

HEPATITIS C THERAPY PRIOR AUTHORIZATION FORM

Please fax to 202-243-6258

Patient Name: _____

Patient DOB: _____ Diagnosis Code(s): _____

Patient Phone #: (____) –_____ - _____

Medication Prescribed: _____ for _____ weeks
(Medication Name)

Please check Yes or No box below:

Yes	No	Requirement
☐	☐	A treatment plan was developed and discussed with patient.
☐	☐	The patient will be able to comply/be adherent with full course of therapy.
☐	☐	The prescriber agrees to complete viral load testing 12 weeks after therapy has ended (to assess SVR).
☐	☐	If the patient's Medicaid eligibility changes during therapy and the patient is no longer eligible for Medicaid prescription drug assistance, the physician is prepared to enroll the patient in other patient-assistance drug program to complete therapy.

Please submit the following medical records including:

a. Most recent office visit note(s) which must have the following details:
   i. List of all previous hepatitis C treatments; if none, the note must say "treatment naïve."
   ii. Child-Pugh score (if cirrhotic).
   iii. Social history with detail provided on use of ETOH and/or illicit substances.
b. Laboratory studies including:
   i. A recent (less than 6 months old) baseline viral load.
   ii. Genotype.
   iii. Fibrosis scoring (FibroSure, FibroTest, FibroScan, liver biopsy).
   iv. (if applicable) HIV viral load and/or hepatitis B viral load.

By signing below, I certify that the information provided is accurate and that all the relevant medical records listed above are included in this submission.

Prescriber's Name: _____

Telephone#: (____) –_____ - _____ Fax#: (____) -_____ - _____

Prescriber Address: _____

Prescriber Signature: _____ Date: _____