

## SOUTH CAROLINA MEDICAID PROGRAM

### PRIOR AUTHORIZATION REQUEST – HEPATITIS C

<b>PRESCRIBER:</b>  <b>NAME:</b> _____ <small>(FIRST) (LAST)</small>  <b>National Provider ID #</b> _____  <b>PHONE #</b> (____) _____  <b>FAX #</b> (____) _____  <b>PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM:</b> _____	<b>BENEFICIARY:</b>  <b>NAME:</b> _____ <small>(FIRST) (LAST)</small>  <b>MEDICAID #:</b> _____  <b>DATE OF BIRTH:</b> ___/___/___ <b>SEX:</b> <input type="checkbox"/> M <input type="checkbox"/> F  <b>REQUEST DATE:</b> ___/___/___
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**PHARMACY:** \_\_\_\_\_ **PHONE:** (\_\_\_\_) \_\_\_\_\_

DRUG NAME	DOSE	STRENGTH	LENGTH OF THERAPY

**DIAGNOSIS:** \_\_\_\_\_  
**GENOTYPE:** \_\_\_\_\_  
**INITIAL VIRAL LOAD:** \_\_\_\_\_

**DATE TAKEN:** \_\_\_/\_\_\_/\_\_\_

**HAS THE PATIENT HAD A LIVER BIOPSY?**  Yes  No

If yes, please document results: \_\_\_\_\_  
 (\*\*Please attach a copy of lab results noted above with this form for our records\*\*)

- |  |  |
|--|--|
| 1. Does the patient have autoimmune hepatitis?                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Is the patient (or patient's partner) pregnant?                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Does the patient have a hemoglobinopathy?<br>(e.g., sickle cell, thalassemia) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Is there a history of kidney, lung or heart transplant?                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Does the patient have untreated hyperthyroidism?                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Does the patient have uncontrolled depression?                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Does the patient have severe HTN, heart failure or CAD?                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Is the patient going to be taking a Ribavirin?                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If not, please explain contraindicaton: \_\_\_\_\_  
 \_\_\_\_\_

South Carolina Medicaid has instituted a program to more closely monitor Hepatitis C patients in an attempt to improve medication compliance. To assist in the program, please provide the patient's phone number(s). \_\_\_\_\_  
 \_\_\_\_\_

<b>SUBMIT REQUESTS TO:</b>	<b>FIRST HEALTH SERVICES</b>	<b>FAX: (888) 603-7696</b>
All Fax requests will be processed in one business day To check on the status you may call <b>TELEPHONE: (866) 247-1181</b>		
<b>WEB REQUESTS:</b> PA's may be requested on-line see the following website for details: <a href="http://southcarolina.fhsc.com/">http://southcarolina.fhsc.com/</a>		