SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

South Carolina Medicaid Program

Prior Authorization Request Form

Hepatitis C – Antiviral Agents

Form must be complete, correct, and legible or the PA process can be delayed.

Request Date: ___ / ___ / _____

I. BENEFICIARY INFORMATION

Patient's First Name:

Patient's Last Name:

Medicaid ID#:

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

Sex: ☐ Male ☐ Female

Patient's Race:

II. PRESCRIBER'S INFORMATION

Prescriber's First Name:

Prescriber's Last Name:

National Provider ID# (NPI):

Prescriber's Specialty:

Prescriber's Phone Number: - -

Prescriber's Fax Number: - -

Prescriber's Office Staff Completing this Form:

Pharmacy:

Pharmacy's Phone Number: - -

III. LAB VALUES/LIVER STAGING/REGIMEN REQUESTED

Do not include documentation that is not requested on this form

Laboratory Documentation					
Baseline HCV RNA level		**Week 4 HCV RNA level**		**SVR 12 Week HCV RNA level**	
Date:	Level:	Date:	Level:	Date:	Level:

Please fill in the data and provide copies of lab data/chart notes with this request within **12 WEEKS** of request)

WBC:		**Serum Albumin:**		**AST:**		**ALT:**	
Hemoglobin:		**Total Bilirubin:**		**Alkaline Phosphatase:**			
Platelet Count:		**Direct Bilirubin:**		**Creatinine:**			
INR:		**Sodium:**		**Height:**		**Weight:**	

Please fill in the data as well as supporting documentation/chart notes (labs data within **12 MONTHS** of request):

HCV Genotype:		**HCV Quantitative RNA:**		**HIV Antibody:**	
HBV quantitative sAB:		**HBV sAg:**		**HBV Total cAb:**	
Staging of Liver Disease:	**Date:**	**Findings/Results:**			
Liver Biopsy (not preferred):					
Ultrasound (if F3/F4):					
HCV FibroSURE Assay:					
Transient Elastography:					

Fax completed forms to Magellan Rx Management.
All fax requests will be processed in one business day.
To check the status of your request, please call or visit our website.

Fax: 888-603-7696
Phone: 866-247-1181
Website: http://southcarolina.fhsc.com/

Revised: March 18, 2019

South Carolina Medicaid Program Prior Authorization Request Form
Hepatitis C – Antiviral Agents

Patient's First Name: | | | | | | | | | | | | | |

Patient's Last Name: | | | | | | | | | | | | | | | | |

1. Please check the box corresponding to the specialty of the prescribing physician:
   ☐ Gastroenterology ☐ Infectious Disease ☐ Hepatology ☐ Other
   – If case was presented at SC Telehealth, please provide date presented: ____________________
2. Is the patient actively participating in illicit substance or alcohol abuse? (If ***NO***, skip to **question #6.**) ☐ Yes ☐ No
3. Does the patient have a past history of illicit substance or alcohol abuse? ☐ Yes ☐ No
   – If ***YES***, attach confirmation that the patient has completed or is participating in a recovery program, or receiving substance or alcohol abuse counseling services, or seeing an addiction specialist as part of Chronic Hepatitis C treatment.
4. Has the patient been free of substance abuse for the previous 6 months? ☐ Yes ☐ No
5. Has the patient been free of alcohol abuse for the previous 6 months? ☐ Yes ☐ No
6. Does the patient have a diagnosis of compensated cirrhosis? ☐ Yes ☐ No
7. Does the patient have decompensated cirrhosis, defined as a Child-Pugh score of greater than 6 (Class B or C)? ☐ Yes ☐ No
   – If ***YES***, will the patient be taking in combination with ribavirin? ☐ Yes ☐ No
8. Which of the following best describes the patient prior to this course of treatment for Hepatitis C?
   ☐ Treatment naïve
   ☐ Prior "null responder" (less than a 2 log decrease in HCV-RNA at treatment week 12)**
   ☐ Prior relapser (undetectable HCV RNA at end of previous treatment, but detectable within 24 weeks after treatment**
   ☐ Prior partial relapser (≥ 2 log decrease in HCV RNA at week 12 of previous treatment, but did not achieve undetectable HCV RNA at end of treatment)**

   ** If treatment-experienced, specific dates/regimens: ____
9. **Preferred Products/Requested Regimen:** ____
   ☐ glecaprevir/pibrentasvir (Mavyret™). **Duration:** __________________
   ☐ sofosbuvir/velpatasvir (Epclusa®). **Duration:** ____________________
10. **Treatment Experienced Only:**
    ☐ sofosbuvir/velpatasvir/voxilaprevir (Vosevi®). **Duration:** __________________
11. Please note any other information pertinent to this PA request:

    ____

    ____

    ____

NOTE: If approved, compliance with therapy is required. Authorizations will be terminated for patients who are noncompliant with therapy.

Prescriber's Signature: ____ **Date:** ____________________

(**On behalf of the Prescriber or Pharmacy Provider, I** certify that the information stated above is a true statement, made for the purposes of inducing South Carolina Medicaid to offer prescription coverage to this individual for the medication requested above. I understand that this document and any attached materials will be **RETAINED FOR THE PURPOSES OF POSSIBLE FUTURE AUDIT.**

Fax this form to: 888-603-7696

Revised: March 18, 2019