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SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

South Carolina Medicaid Program

Prior Authorization Request Form

Hepatitis C – Antiviral Agents

Request Date: ___ / ___ / _____

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

I. BENEFICIARY INFORMATION

Patient's First Name:

Patient's Last Name:

Medicaid ID#:

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

Sex: ☐ Male ☐ Female

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	**SVR 12 Week HCV RNA level**
Date: Level:	Date: Level:

Please fill in the data and provide copies of lab data/chart notes with this request (within **6 MONTHS** of request):

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

Please fill in the data as well as supporting documentation/chart notes (labs data within **6 MONTHS** of request):

HCV Genotype:		**HCV Quantitative RNA:**		**HIV Antibody:**	
HBV sAg:					
Staging of Liver Disease:		**Findings/Results:**			
Option 1:	**APRI*[1]**				
Option 2:	**FIB-4 Score*[2]**				
Option 3:	**FibroSURE Assay or similar test***				
Ultrasound (only if F3/F4):					

- **In most cases, 2 of 3 options are adequate.**
- **[1] AST/Platelet Ratio Index; [2] FIB-4 (calculated from AST, ALT, platelets, and age)**

Fax completed forms to Prime Therapeutics Management LLC.
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/

Prime THERAPEUTICS™

Revised: May 03, 2023

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

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

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

1. Does the patient have a diagnosis of compensated cirrhosis? ☐ Yes ☐ No
   a. If **YES**,
      i. What are the results of most recent ultrasound (last 6 months)? _____
      ii. Has the case been presented at the Southeast Viral Interactive Case Conference (SVICC) (https://www.seaetc.com/calendar/)? If so, provide the case number and date presented.
      _____

   Note: screening ultrasounds are recommended every 6 months in all patients with cirrhosis.
2. Does the patient have decompensated cirrhosis, defined as a Child-Turcotte-Pugh score of ≥ 7 (i.e., Class B or C)? ☐ Yes ☐ No
   a. If **YES**, will the patient be taking in combination with ribavirin? ☐ Yes ☐ No
      i. Has the patient been referred to a transplant center or subspecialty care (e.g., gastroenterology, hepatology, infectious disease)? ☐ Yes ☐ No
      ii. Has the case been presented to the Southeast Viral Interactive Case Conference (SVICC) (https://www.seaetc.com/calendar/)? If so, provide the case number and date presented.
      _____
3. Which of the following applies to the patient?
   ☐ Treatment naïve
   ☐ Treatment experienced:
      i. Interferon plus ribavirin regimen _____
      Note: if treated previously with interferon alone, then consider the patient treatment naïve.
      ii. Direct acting antivirals _____
      iii. Specific drug and duration of therapy: _____
4. If the patient is treatment naïve, what are the preferred products or requested regimen for treatment? (Check one.)
   ☐ Mavyret® (glecaprevir/pibrentasvir) **Duration:** _____
   ☐ sofosbuvir/velpatasvir (Epclusa®) **Duration:** _____
   ☐ Other: _____ **Duration**: _____
5. If the patient is treatment experienced, what are the preferred products or requested regimen for treatment? (Check one.)
   ☐ Vosevi® (sofosbuvir/velpatasvir/voxilaprevir) **Duration:** _____
   ☐ Other: _____ **Duration**: _____
6. Note any other information pertinent to this prior authorization request (e.g., current chart notes, current medications, lab results).

_____

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.**

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