Print Reset

Idaho Department of Health and Welfare
ADAP Program
Provider Certification Prior Authorization Form – Hepatitis C

Please complete and return via fax to **800-424-7579.**

A request for the patient identified below has been made for the dispensing of hepatitis C medication. The Department of Health and Welfare requires more information before this prescription can be paid by the Idaho Department of Health and Welfare ADAP program.

PATIENT INFORMATION

Last Name: _____ First Name: _____

ADAP Cardholder ID #: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

HEALTHCARE PROVIDER INFORMATION

Last Name: _____ First Name: _____

NPI #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

PRESCRIPTION INFORMATION

1. Select appropriate drug:
   - ☐ Mavyret® 100/40 mg (3 tablets daily) preferred regimen
   - ☐ Harvoni® 90/400 mg (1 tablet daily) preferred regimen
   - ☐ Epclusa® 100/400 mg (1 tablet daily) preferred regimen
   - ☐ Vosevi® 400/100/100 mg (1 tablet daily) for treatment failure requests only
2. Select requested duration of therapy:
   - ☐ 8 weeks
   - ☐ 12 weeks
   - ☐ 24 weeks
   - ☐ 48 weeks
   - ☐ Other: _____
3. List requested treatment start date: _____

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Last Name: _____ **First Name:** _____

CLINICAL REQUIREMENTS

1. Does the patient have chronic Hepatitis C? ☐ Yes ☐ No
   a. Date of initial diagnosis: _____
   b. HCV genotype: _____
   c. Fibrosis score: _____
   d. Pre-treatment quantitative HCV RNA result taken within the last year (provide documentation):

2. Is the patient treatment naïve? ☐ Yes ☐ No
   a. If NO, what other treatments have been tried? Please supply medication name, as well as treatment durations.

3. Has the patient received harm-reduction counseling? ☐ Yes ☐ No

4. Has the patient received screening for hepatitis A and B? ☐ Yes ☐ No
   If YES, answer questions below:
   a. If negative, has patient received vaccination? ☐ Yes ☐ No
   b. If tested positive for Hepatitis B infection, list suppressive therapy: _____

For Vosevi® Requests Only:

5. Has the patient failed treatment previously? ☐ Yes ☐ No

6. What are the previous therapies and dates of treatment?

HEALTHCARE PROVIDER'S CERTIFICATION

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 Signature: _____ **Date:** _____

Fax this form to 800-424-7579 or mail to Prime Therapeutics Management LLC, Attn: GV – 4201, P.O. Box 64811, St. Paul, MN 55164-0811.