



FCHP pharmacy prior authorization form
Hepatitis C - Initial Request

Fax completed form to 1-508-791-5101. For urgent situations, please call 1-866-275-3247 and select option 5. Services are subject to coverage, benefit, network and contract policies and exclusions.

Patient information

Last name:
DOB:
Medicare member? Yes No

First name: MI:
FCHP ID #:

Physician information

Physician name:
Phone:
Signature:

Specialty:
Fax:
Date: NPI:

Medications requested

Peg-Intron strength: frequency:
Ribavirin strength: frequency:
Other:

Incivek strength: frequency:
Victrelis strength: frequency:
Other:

Diagnosis ICD-9 code (required):
Expected duration of therapy:

Diagnosis description:

Please forward clinical notes from the patient's medical records documenting diagnosis (including any applicable labs and /or tests) and the below requested information. This is required information.

What is the patient's genotype? What is the current patient's weight? lbs or kg
What is the patient's current HCV RNA level? Date

Does the patient have:

- cirrhosis Yes No
hepatitis B Yes No
HIV Yes No
an organ transplant Yes No
autoimmune hepatitis Yes No
decompensated liver disease Yes No

- hemoglobinopathy Yes No
creatinine clearance less than 50 Yes No
positive pregnancy test Yes No
previous treatment with Incivek or Victrelis Yes No
previous treatment with interferon or ribavirin Yes No

If previously treated with peg-interferon or ribavirin, please complete the following based on PREVIOUS treatment:

When was the patient treated? What was the length of therapy?
What was the response type? partial responder non-responder relapser

What were the HCV RNA levels at:

Table with 3 columns: Time point (Baseline, Week 4, Week 12, Week 24, Completion, 24 weeks after completion), HCV RNA level, Date.

If request is for Pegasys, please complete the following:

Our preferred agent is Peg-Intron. Pegasys will only be approved if the patient was intolerant to Peg-Intron. Has the patient tried and was intolerant to Peg-Intron? Yes No
If yes, please indicate the adverse effects experienced:
Is there any reason why Peg-Intron could not be used? (Please explain):
If prescribing Peg-Intron, please indicate strength here

If request is for Ribapak, please complete the following:

It is more cost effective to use ribavirin 200 mg tablets/capsules rather than Ribapak. Is there any reason why the patient could not use ribavirin 200mg tablets or capsules? Please explain:
If prescribing ribavirin 200 mg tabs/caps, please indicate dosage form here

Fallon Senior Plan pre-service denial

Complete this section only for Fallon Senior Plan members when declining to submit a prior authorization for a medication requested by the member. FCHP will notify the submitting physician and member of the determination. Please provide all information requested.

- 1. Medication requested by member:
2. Member's reason for request: