



FCHP pharmacy prior authorization form Hepatitis C - Renewal

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: _____

First name: _____ MI: _____

DOB: _____

FCHP ID #: _____

Medicare member? Yes No

Physician information

Physician name: _____

Specialty: _____

Phone: _____

Fax: _____

Signature: _____

Date: _____ NPI: _____

Medications requested

Peg-Intron strength: _____ frequency: _____

Incivek strength: _____ frequency: _____

Ribavirin strength: _____ frequency: _____

Victrelis strength: _____ frequency: _____

Other: _____

Other: _____

Diagnosis ICD-9 code (required): _____

Diagnosis description: _____

Expected duration of therapy: _____

Please forward clinical notes from the patient's medical records documenting the below requested information and the patient's current response to therapy. This is required information.

Please complete the clinical information requested below from baseline through the patient's current week of therapy.

	HCV RNA level	HCV RNA Log	Date
Baseline			
Week 4			
Week 8			
Week 12			
Week 24			

What is the patient's weight? _____ lbs or kg date _____

Does the patient have:

cirrhosis Yes No

hemoglobinopathy Yes No

hepatitis B Yes No

creatinine clearance less than 50 Yes No

HIV Yes No

positive pregnancy test Yes No

an organ transplant Yes No

autoimmune hepatitis Yes No

decompensated liver disease Yes No

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: _____