Neighborhood Health Plan OF RHODE ISLAND™

Walgreens

335 Prairie Ave, Providence, RI 02905
Phone: 1-401-781-4390
Fax: 1-401-781-4645

Hepatitis C
Prior Authorization Form
Pharmacy Dept Phone: 1-401-427-8200
Fax: 1-866-423-0945

Instructions:

- The form is to be used by participating physicians and providers to obtain coverage for drugs to treat Hepatitis C.
- Please complete and fax this prior authorization form along with all applicable documentation required directly to Neighborhood Health Plan of Rhode Island at 1-866-423-0945 to prevent any delays in review.
- Please fax the prescription to the local Walgreens Pharmacy located at 335 Prairie Ave in Providence, RI at 1-401-781-4645.

MEMBER INFORMATION		
Member's Name:	Member's ID Number:	Member's DOB:

PRESCRIPTION INFORMATION			
Medication Name/Strength	Directions	Quantity	Refills

PRESCRIBER INFORMATION

Prescriber's Name: _____ Specialty: _____

Address:_____

City:_____ State:_____ Zip Code: _____

Phone #:_____Fax #: _____

Office Contact Name: _____Prescriber's NPI #: _____

In order for a brand name product to be dispensed, the prescriber must handwrite "**Brand Necessary**" or "**Brand Medically Necessary**," or your state specific required language to prohibit substitution: I certify that the above therapy is medically necessary and that the information submitted is accurate to the best of my knowledge.

Prescriber's Signature Required: _____ Date: _____

CLINICAL ASSESSMENT (Complete all requested information)	
Treatment Status:	❑ Treatment naïve ❑ Retreatment (prior treatment failure with another HCV agent) *If request is for Vosevi, no further information is required. ❑ Currently on therapy: Provide Start Date: _____
Provide previous Hepatitis C drug therapy (if applicable):	Drug(s):_____Date(s): _____ ❑ Side effect ❑ Inadequate response ❑ Other: _____
Hepatitis C Genotype:	❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑Other:____
Hepatic Fibrosis Stage:	❑ stage 0 ❑ stage 1 ❑ stage 2 ❑ stage 3 ❑ stage 4
Test used to determine disease stage (check all that apply): Documentation must be submitted with PA request	❑ AST to Platelet Ratio Index (APRI) ❑ Fibroscan score ❑ Fibrotest score ❑ Imaging study ❑ Liver biopsy indicating METAVIR score ❑ Other, please specify: _____
Is cirrhosis present?	❑ Yes - If yes, ❑ Compensated Cirrhosis **or** ❑ Decompensated Cirrhosis ❑ No
If requested, does the prescriber agree to submit post treatment viral load data?	❑ Yes ❑ No
Rationale as to why member is unable to use preferred HCV agents Mavyret and/or Vosevi. Clinical documentation must be provided.	