



HEPATITIS C PROTEASE INHIBITORS (INCIVEK®/VICTRELIS®)

Prior Authorization/Prescription/Patient Enrollment Form

Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION			
Last Name		First Name	Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #	
Allergies: <input type="checkbox"/> NKA or _____			
Street Address			City
State	County	Zip Code	
Home Phone		Cell Phone	
Parent/Guardian		Day Telephone	Night Telephone
Emergency Contact		Relationship	Telephone

2 PRESCRIBER INFORMATION			
Prescriber's Name		NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name	
Street Address			City
State	County	Zip Code	
Contact Person at Office		Prescriber Specialty	



Fax Completed Form to:
Fax Number: 800-218-3221
Phone Number: 866-843-3604

3	Department of Vermont Health Access HEPATITIS C PROTEASE INHIBITORS PRIOR AUTHORIZATION REQUEST
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Patient Diagnosis:	Genotype:
If requesting prescriber is not a Hepatologist, Gastroenterologist or ID Specialist, has one of these specialties been consulted on this case? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Specialist name: _____ Specialist Type: _____	
Requested Hepatitis C Protease Inhibitor? <input type="checkbox"/> Incivek®: 375 mg tablet <input type="checkbox"/> Victrelis®: 200 mg capsule	
Patient is treatment naive? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, previous response to peg-interferon/ribavirin <input type="checkbox"/> Null responder <input type="checkbox"/> Partial responder <input type="checkbox"/> Relapser	
Patient has had previous therapy with Incivek® or Victrelis®? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please specify: _____ (agent) ___/___/___ (date) _____ (response)	
Most recent HCV-RNA level: _____ IU/mL Date: ___/___/___	
Patient has cirrhosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ribavirin/peg-interferon will be used concomitantly <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ribavirin/peg-interferon PA form included <input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>or</u>	
Patient has started Ribavirin/peg-interferon therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, date therapy initiated: ___/___/___	
Prescriber Additional Comments:	

4	PRESCRIPTION
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<input type="checkbox"/> Incivek®: 375 mg tablet	Sig: 750 mg PO TID with food	Qty: 168 tablets (28 days)
<input type="checkbox"/> Victrelis®: 200 mg capsule	Sig: 800 mg PO TID with food	Qty: 336 capsules (28 days)
Refill X _____	Note: TID is q 7 – 9 hours	
** HCV-RNA levels will be required per protocol (required for certain refills) **		
Deliver product to: <input type="checkbox"/> Patient's home <input type="checkbox"/> MD office <input type="checkbox"/> Clinic		
Prescriber's Signature: _____		Date: _____