



HEPATITIS C MEDICATIONS – Peg-Interferon/Ribavirin

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 MEDICATIONS– Peg-Interferon/Ribavirin PRIOR AUTHORIZATION REQUEST

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: _____	
Most recent HCV-RNA level: _____ IU/mL Date: ____/____/____	
Requested DVHA PREFERRED Oral Hepatitis C Product? <input type="checkbox"/> Ribavirin 200 mg Tab (compare to Copegus®) <input type="checkbox"/> Ribavirin 200 mg Cap (compare to Rebetol®) or Product: _____ Medical justification: _____	
Requested DVHA PREFERRED Injectable Hepatitis C Product? <input type="checkbox"/> Pegasys® Prefilled Syringe <input type="checkbox"/> Pegasys® Single Dose Vial <input type="checkbox"/> Pegasys® ProClick or Product: _____ Medical justification: _____	
Patient will also be receiving (Please complete Hepatitis C Protease Inhibitors PA Form) <input type="checkbox"/> Incivek® <input type="checkbox"/> Victrelis® <input type="checkbox"/> Neither	

4

PRESCRIPTION

Oral: <input type="checkbox"/> Ribavirin 200 mg <input type="checkbox"/> Tablet <u>or</u> <input type="checkbox"/> Capsule <input type="checkbox"/> Other (Specify): _____ Dose: _____ Frequency: _____ Qty: <u>28 days supply</u> Refill X: _____
Injectable: <input type="checkbox"/> Pegasys® Prefilled Syringe 180 mcg/0.5 ml "Convenience Kit" (4 syringes/box) or <input type="checkbox"/> Pegasys® 180 mcg/1 ml Single Dose Vial or <input type="checkbox"/> Pegasys® ProClick <input type="checkbox"/> 180 mcg/0.5 ml <u>or</u> <input type="checkbox"/> 135 mcg/0.5 ml or <input type="checkbox"/> Other (specify): _____
Sig: Dose/Route/Frequency: _____
Dispense Quantity: <u>28 days supply</u> Refill X: _____
<input type="checkbox"/> Needles/syringes: quantity sufficient for drug supply with refills as above
Deliver product to: <input type="checkbox"/> Patient's home <input type="checkbox"/> MD office <input type="checkbox"/> Clinic
Prescriber's Signature: _____ Date: _____