



HEPATITIS C MEDICATIONS

Prior Authorization/Prescription/Patient Enrollment Form

Complete form in its entirety and fax to number listed below

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		Day Telephone		Night Telephone	
Parent/Guardian		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

Department of Vermont Health Access HEPATITIS C MEDICATIONS/PRIOR AUTHORIZATION REQUEST

Patient Diagnosis: Hepatitis C YES NO

If YES, Hepatitis C Supplemental Clinical Form must be completed and submitted for PA request to be considered.

Requested DVHA PREFERRED Ribavirin Hepatitis C Product?

Ribavirin 200 mg Tablet (compare to Copegus®) or

Product: _____ Medical justification: _____

Requested DVHA PREFERRED Injectable Pegylated Interferon Hepatitis C Product?

Pegasys® Prefilled Syringe Pegasys® Single Dose Vial Pegasys® ProClick or

Product: _____ Medical justification: _____

Polymerase Inhibitor

Sovaldi® (sofosbuvir) 400 mg Tablet

Protease Inhibitor

Olysio® (simeprevir) 150 mg Capsule or

Product: _____ Medical justification: _____

4 PRESCRIPTION

Oral Ribavirin:

Ribavirin 200 mg Tablet Refill for total: _____ weeks

Sig: Dose/Frequency: _____ Quantity 28 days' supply

Injectable Pegylated Interferon:

Pegasys® Prefilled Syringe 180 mcg/0.5 ml "Convenience Kit" (4 syringes/box)

Pegasys® 180 mcg/1 ml Single Dose Vial

Pegasys® ProClick 180 mcg/0.5 ml or 135 mcg/0.5 ml

Sig: Dose/Route/Frequency: _____ Refill for total: _____ weeks

Oral Polymerase Inhibitor:

Sovaldi® (sofosbuvir) 400 mg Tab Sig: Take one tablet (400 mg) by mouth once daily.

Dispense Quantity: 28 (4 weeks) Refill for total: _____ weeks

Oral Protease Inhibitor:

Olysio® (simeprevir) 150 mg Sig: Take one cap (150 mg) by mouth once daily with food.

Dispense Quantity: 28 (4 weeks) Refill for total: _____ weeks

Needles/syringes: quantity sufficient for drug supply with refills as above

Deliver product to: Patient's home MD office Clinic

Prescriber's Signature: _____ Date: _____