STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110 or (860) 269-2035

Hepatitis C Prior Authorization (PA) Request Form
CT Medical Assistance Program

To Be Completed By Prescriber

Prescriber Information	**Patient Information**
Prescriber's NPI:	Client Medicaid ID Number:
Prescriber Name:	Patient Name:
Phone # ( )	Patient DOB:
Fax # ( )	Primary ICD diagnosis code:
Prescription Information	
Drug Requested (Preferred Agents Listed): □ Sofosbuvir/Velpatasvir 400/100 mg by mouth once daily □ Mavyret 100/40 mg three tablets by mouth once daily □ Vosevi 400/100/100 mg by mouth once daily	□ New therapy □ Continuation Expected Start Date: Expected Duration (weeks):
□ Other: _____ **(Non-Preferred Agents – Please explain why the patient cannot be treated with a preferred alternative.)**	

Payment will be authorized for 4 weeks of medication, with further refills available every 4 weeks.
The prescriber agrees to obtain all FDA recommended tests, including pregnancy tests, if applicable, and to monitor as appropriate according to evidence-based guidelines for the entire duration of therapy.

Clinical Information

1.	Is the patient 18 years of age or older?	□ Yes	□ No
2.	Does the patient have a diagnosis of Chronic Hepatitis C infection of any genotype 1-6 confirmed by HCV ribonucleic acid (RNA) level?	□ Yes	□ No
3.	Is the patient free of any known or suspected malignancy of any organ diagnosed within the last 12 months; And/is the patient not receiving and/or not planning to receive chemotherapy or radiation therapy?	□ Yes	□ No
4.	Is the patient free of any evidence of a known terminal disease, with life expectancy of fewer than 12 months; And/or is the patient not enrolled in hospice?	□ Yes	□ No

If you answered 'NO' to any of the questions above, or if you are requesting more than 12 weeks of total therapy, a Letter of Medical Necessity (LMN) must be reviewed for consideration. Please provide all relevant information relating to the medical necessity including the patient's specific genotype (see Conn. Gen. Stat § 17b-259b(a)) for the requested medication for this patient. Submit request via email to rx.lmn@ct.gov

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.

I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99of the Connecticut General Statutes and sections 17-83k-1-13 and 4a-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the client is under my clinic's/practice's ongoing care. I certify that I am a practitioner and hold a current, unrestricted license that allows me to prescribe medication and that I am enrolled in the CT Medical Assistance Program.

Prescriber Signature*: _____ **Date:** _____

* Mandatory (others may not sign for prescriber). **In accordance with federal law, prescribers must be enrolled in the Connecticut Medical Assistance Program (CMAP). CMAP will not pay for prescriptions written by a non-enrolled provider.**