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

CT Medical Assistance Program Hepatitis C Prior Authorization (PA) Request Form
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): □ Epclusa 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:
□ Other*: _____ (Non-Preferred Agents – Please explain why the patient cannot be treated with a preferred alternative.)	

Payment will be authorized for 2 weeks of medication, with further refills available every 2 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

Is the patient 18 years of age or older?	□ Yes □ No
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
Does the patient have evidence of or a known malignancy of any organ diagnosed within the last 12 months?	□ Yes □ No
Is the patient currently receiving or planning to receive chemotherapy or radiation therapy?	□ Yes □ No
Does the patient have evidence of or a known terminal disease, with life expectancy of fewer than 12 months?	□ Yes □ No
Is the patient currently enrolled in hospice?	□ Yes □ No
Does the patient need more than 12 weeks of therapy?	□ Yes □ No

If you are requesting more than 12 weeks of therapy, please explain and include the patient's specific genotype:
_____
_____

*Please note if this patient has hepatocellular carcinoma or provide any other information relating to the medical necessity (see Conn. Gen. Stat. § 17b-259b(a)) of this drug for this patient:_____
_____
_____

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-99 of 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:_____