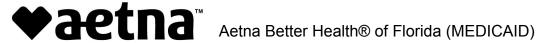


HEPATITIS C AGENTS

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID#										Date of Birth (MM/DD/YYYY)																				
														1			1													
Rec	ipient	's Fu	ıll N	ame	l					_																				
_																										<u> </u>				
Pre	scribe	r's F	ull N	Name	9																					\top				
Pre	scribe	r's N	IPI		l					7																				
Pre	scribe	r's P	hon	e Nı	ımbe	er	1			_	1	7						Pre	esc	ribe	er's	Fax	Nun	ber		_				ı
			-				-															-				-				
	eferre																													
Phy	/sicia	 n m	ust	sub	mit :	all s	upp	ortin	ng de		men	tatio	on in		ding	lab	resi	ults.							·					
1	nysician must submit all supporting document Does the recipient have chronic hepatitis C? (Subm										uhm	it qur	-													☐ Yes			Г] No
••	If YES		-					-		-		-	-	_	ooun	TOTTLE		,									00			
2.	What														lts)] 1a] 1	b		2	□ 3		□ 4		<u></u> 5] 6
3.	. Has the recipient been previously treated with HCV therapy?																								☐ Y	es] No	
	If YES	If YES, please specify date, treatment regimen, and duration:																												
	If YES	S, ple	ease	docı	ımer	nt res	pons	se to	thera	ру:						Nu	ıll res	pon	der] Pa	artial	resp	onde	er	□R	elap	ser		
4.	Does the recipient have chronic HCV with cirrhosis?										(Supporting documentation required.)														Yes] No	
	If cirrh	osis	, wh	at typ	oe?] Co	mpe	nsat	ed] De	econ	npen	sated	t					
5.	Child-	Pual	h Sc	ore:	(Suh	mit s	นทุกก	ortina	docı	ımer	ntatio	n.)														ПΑ		Пв	Г	1 c



HEPATITIS C AGENTS

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Full Name																											
6.	Has the patient recently been tested for Hepatitis B Virus infection? (Current lab work must be included.)															Yes			□No								
7.	Does the recipient have hepatocellular carcinoma?															☐ Yes			☐ No								
8.	Is the recipient HIV co-infected? (Must have documented diagnosis and must submit most recent CD4 count – within last 6 months.)																☐ Ye] No					
9.	Liver transplant? (If YES, please specify date and submit supporting documentation.)																										
	☐ Awaiting liver transplant (date): ☐ No ☐ Post-transplant																										
10.	10. Indicate HCV RNA level: (Must submit lab results within the past six months for baseline.)																										
		Treatment week Log10 Date Measured																									
	Pre-tr	eatme	nt ba	asel	ine																						
11.	Has the recipient committed to the documented planned course of treatment, inclusive of anticipated blood tests and physician visits, during and after treatment?														☐ Yes			☐ No									
12.		For ribavirin therapy: If the patient is a female of childbearing potential, has a negative pregnancy test within 30 days of initiating therapy been submitted?															☐ Yes			☐ No							
13.		Has recipient abstained from illicit drugs and/or alcohol consumption for a minimum of 1 month? (Must submit results of test.)																☐ Y€	es	☐ No							
	OR																										
14.		Is the recipient receiving substance or alcohol abuse counseling services? (Must submit supporting documentation.)														☐ Yes			□ No								
Ву	signing	below	, the	e pr	escril	oer a	ıttest	s tha	it all s	taten	nen	ıts p	rovi	ded	are	accu	ırate	-									
Pres	Prescriber's Signature: Date:																										
	REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes) and the most recent copies of related labs. The provider must retain copies of all documentation for five years.																										

Fax completed prior authorization request form to Aetna Better Health of Florida at 855-799-2554 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (via return fax) immediately and arrange for the return or destruction of these documents. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.