



PRIOR AUTHORIZATION REQUEST FORM FOR HEPATITIS C TREATMENT

Instructions: Please complete ALL FIELDS and FAX COMPLETED FORM TO 1-866-388-1767

Visit our website for Prior Authorization criteria at www.wellcare.com

Member Name		Prescriber FULL Name/Specialty			
Wellcare ID #	Date of Birth	Prescriber NPI			
Member's Telephone Number		Office Address			
Diagnosis for use of the requested medication(s):					
Hepatitis C Genotype	Patient Weight (lbs)	Contact Name at MD Office			
Does the patient have Human Immunodeficiency Virus (HIV)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Office Phone #			
Does the patient have decompensated liver disease? <input type="checkbox"/> Yes <input type="checkbox"/> No		Office Fax #			
REQUESTED MEDICATION(S)					
Drug Name	Drug Strength	Drug Dosage Form	Length of Treatment		
New start or a continuation of therapy? <input type="checkbox"/> New start <input type="checkbox"/> Continuation Start Date: _____					
Pertinent past or present therapies (including OTCs and non-pharmacological): (MUST attach comprehensive list or complete form)					
Drug & Dose Used	Route	Frequency	Start Date	Stop Date	Therapeutic Outcome
REQUIRED DOCUMENTATION – Please submit all required clinical notes/lab reports in reference to this request.					
If awaiting liver transplant, is the patient suitable for transplant per Milan criteria? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Side effects and length of therapy have been explained to member and documented by physician. The member understands the importance of adherence and completion of the medication protocol. <input type="checkbox"/> Yes <input type="checkbox"/> No					
Child Pugh Score: _____ Platelet count: _____ Total Serum Bilirubin: _____ Albumin: _____					
INR: _____ Ascites: <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatic Encephalopathy: <input type="checkbox"/> Yes <input type="checkbox"/> No CrCl: _____					
Liver Biopsy: <input type="checkbox"/> Metavir Score: _____ <input type="checkbox"/> Ishak Score: _____ <input type="checkbox"/> Other _____					
BASELINE LAB DATA (REQUIRED FOR APPROVAL)					
Viral Load: _____ IU/mL AST: _____ ALT: _____					

By signing below, you attest that all statements on this form are true to the best of your knowledge.

Prescriber's Signature _____ Date _____