FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR HEPATITIS C AGENTS RENEWAL

Instructions: Type or print clearly. Before completing this form, refer to the Prior Authorization Drug Attachment for Hepatitis C Agents Renewal Completion Instructions, F-01248A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage* for the completion instructions:

- Prescribers are required to submit the completed, signed, and dated Prior Authorization Drug Attachment for Hepatitis C Agents Renewal to the pharmacy where the prescription will be filled.
- Pharmacy providers are required to have a completed Prior Authorization Drug Attachment for Hepatitis C Agents Renewal form signed by the prescriber before submitting a prior authorization (PA) request. Providers are required to submit the completed Prior Authorization Drug Attachment for Hepatitis C Agents Renewal with the Prior Authorization Amendment Request, F-11042, to ForwardHealth on the Portal, by fax, or by mail.
- Providers may call Provider Services at 800-947-9627 with questions.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number

3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION

4. Provide the member's complete hepatitis C drug treatment regimen.

Drug Name _____ Daily Dose _____ Expected Duration _____

Drug Name _____ Daily Dose _____ Expected Duration _____

Drug Name _____ Daily Dose _____ Expected Duration _____

5. Name — Prescriber

6. National Provider Identifier — Prescriber

7. Address — Prescriber (Street, City, State, ZIP+4 Code)

8. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION FOR RENEWAL

Note: **A copy of the member's hepatitis C virus ribonucleic acid (HCV-RNA) level lab results must be submitted with each renewal request.**

9. Approved PA Number

10. Date Member Began Therapy

11. Indicate the member's HCV-RNA level at treatment **week 4** and the date it was taken.

HCV-RNA Level _____ IU / mL Date Taken _____

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SECTION III — CLINICAL INFORMATION FOR RENEWAL (Continued)

12. Indicate the member's HCV-RNA level at treatment **week 12** and the date it was taken.

HCV-RNA Level _____ IU / mL Date Taken _____

13. If additional HCV-RNA levels were drawn, indicate the following:

Treatment Week _____ HCV-RNA Level _____ IU / mL Date Taken _____

Treatment Week _____ HCV-RNA Level _____ IU / mL Date Taken _____

SECTION IV — AUTHORIZED SIGNATURE

14. **SIGNATURE —** Prescriber	15. Date Signed

SECTION V — ADDITIONAL INFORMATION

16. Include any additional information in the space below, including additional diagnostic and clinical information explaining the need for the drug.

Reset Form