

**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](http://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 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 \_\_\_\_\_

Currently taking?  Yes  No If yes, enter the date started. \_\_\_\_\_

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Currently taking?  Yes  No If yes, enter the date started. \_\_\_\_\_

Drug Name \_\_\_\_\_ Daily Dose \_\_\_\_\_ Expected Duration \_\_\_\_\_

Currently taking?  Yes  No If yes, enter the date started. \_\_\_\_\_

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 need to 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 measured.

HCV-RNA Level \_\_\_\_\_ IU / mL Date Measured \_\_\_\_\_

*Continued*



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**SECTION III — CLINICAL INFORMATION FOR RENEWAL (Continued)**

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

HCV-RNA Level \_\_\_\_\_ IU / mL      Date Measured \_\_\_\_\_

13. Indicate the member's HCV-RNA level at treatment **week 20** and the date it was measured.

HCV-RNA Level \_\_\_\_\_ IU / mL      Date Measured \_\_\_\_\_

14. Indicate the member's HCV-RNA level at treatment **week 28** and the date it was measured.

HCV-RNA Level \_\_\_\_\_ IU / mL      Date Measured \_\_\_\_\_

15. Indicate the member's HCV-RNA level at treatment **week 36** and the date it was measured.

HCV-RNA Level \_\_\_\_\_ IU / mL      Date Measured \_\_\_\_\_

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**SECTION IV — AUTHORIZED SIGNATURE**

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16. **SIGNATURE** — Prescriber

17. Date Signed

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**SECTION V — ADDITIONAL INFORMATION**

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

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