WellCare Health Plans

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)? ☐ Yes ☐ No		Office Phone #
Does the patient have decompensated liver disease? ☐ Yes ☐ No		Office Fax #

REQUESTED MEDICATION(S)

Drug Name	Drug Strength	Drug Dosage Form	Length of Treatment

New start or a continuation of therapy? ☐ New start ☐ 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? ☐ Yes ☐ 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. ☐ Yes ☐ No

Child Pugh Score: _____ Platelet count: _____ Total Serum Bilirubin: _____ Albumin: _____

INR: _____ Acscites: ☐ Yes ☐ No **Hepatic Encephalopathy:** ☐ Yes ☐ No **CrCl: _____**

Liver Biopsy: ☐ **Metavir Score: _____** ☐ **Ishak Score: _____** ☐ **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_____

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