



# New Hampshire Medicaid Fee-for-Service (FFS) Program Prior Authorization/Non-Preferred Drug Approval Form

Hepatitis C Medications

DATE OF MEDICATION REQUEST:    /    /

## SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER:  Male  Female

Drug Name

Strength

Dosing Directions

Length of Therapy

## SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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## SECTION III: CLINICAL HISTORY

- Is the prescriber a gastroenterologist, hepatologist, or infectious disease specialist, or has one of these specialists been consulted in this case?  Yes  No  
If *no* to question 1, has the prescriber completed continuing education related to Hepatitis C?  Yes  No
- Does the patient have a diagnosis of Hepatitis C?  Yes  No
- Has the patient been treated for Hepatitis C in the past?  Yes  No  
If yes to question 3, document patient's prior treatment and genotype:
- Does the patient have a diagnosis of HIV or cirrhosis?  Yes  No
- Has the patient been tested for Hepatitis B (using HbsAg and anti-HBc)?  Yes  No
- Will the patient be on concurrent proton pump inhibitor?  Yes  No

(Form continued on next page.)

