Hepatitis C Retreatment Supplemental Form

(to be completed *in addition to* the Hepatitis C Prior Authorization Form if the patient has previously been treated for hepatitis C)

West Virginia Medicaid
Drug Prior Authorization Form

https://dhhr.wv.gov/bms/BMS%20Pharmacy/Pages/default.aspx

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Patient Name (Last) | (First) | (M) | WV Medicaid 11 Digit ID# | Date of Birth (MM/DD/YYYY)

Prescriber Name (Last) | (First) | (MI)

Prescriber Address (Street) | (City) | (State) | (Zip)

(State): West Virginia

Prescriber 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Pharmacy Name (if applicable)

Pharmacy Address (Street) | (City) | (State) | (Zip)

(State): West Virginia

Pharmacy 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Important Notes: Preauthorization for medical necessity does not guarantee payment.
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Drug Name | Strength | Route of Administration

Directions | Diagnosis | ICD Diagnosis Code (if available)

Previous Treatment Course Details: (Please attach previous genotype lab and SVR12 lab)

Date Range of Previous Treatment: / / to / /

Previous Medication | Previous Infection Genotype | Previous Infection SVR12 Date and Result: / /

Was the patient compliant on the previous course (few to no missed doses)? If no, please document the reason(s) for noncompliance. ☐ Yes ☐ No

Additional Comments:

Retreatment Course Details and Plan:

Current Infection Genotype

Reason for retreatment:

☐ Treatment Failure ☐ Reinfection ☐ Other (explain)

Describe any factors (in addition to noncompliance) that led to treatment failure/reinfection in this patient.

How have the factors listed above (including noncompliance) been addressed with the patient to prevent repeated treatment failure/reinfection?

Has the patient received education regarding risk behaviors associated with HCV infection?

Please briefly outline the plan for monitoring for adherence and successful completion of the retreatment course.

Date of next follow-up appointment

Next appointment setting (i.e. In-Person, Virtual, Telephone, etc)

Planned frequency of follow-up appointments

Future follow-up appointment settings (i.e. In-Person, Virtual, Telephone, etc)

Additional Comments (attach additional pages if necessary):

Does the prescriber attest that the patient is willing and able to comply with the requirements of the above treatment plan? ☐ Yes ☐ No

Does the prescriber attest that any factors that may have led to noncompliance with the previous treatment(s) have been addressed? ☐ Yes ☐ No

Attestation: Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

☐ Check here for electronic signature

Prescriber or Pharmacist Signature

Date: (MM/DD/YYYY)