Texas Standard Prior Authorization Form - Refill Request
Antiviral Agents for Hepatitis C Virus

envolve Pharmacy Solutions

Please complete all fields and **fax to Envolve Pharmacy Solutions at 1-866-399-0929** for Hepatitis C Virus (HCV) treatment refills. Initial prior authorization (PA) requests should be completed using the Texas Standard *Prior Approval Initial Request Form*. **Prior authorization must be requested every 6 weeks for therapy continuation.** Labs are required for weeks 4 and 12 of therapy. Please review Section 3 for timelines. Failure to provide documentation of labs may result in prior authorization denial.

Superior follows the Texas Vendor Drug Program clinical prior authorization criteria for Hepatitis C medications.

1. Patient Information

Name (Last, First):	Medicaid ID Number:	Date of Birth: (mm/dd/ccyy)
Gender: ☐ Male ☐ Female	Current Weight: ☐ lbs. ☐ kg.	Therapy start date:

2. Prescriber Information

Prescriber Information (Accepted specialties include gastroenterology, hepatology, and infectious disease)		
Prescriber Name:	NPI Number:	State license Number:
Phone:	Fax:	Prescriber Specialty:
Consulting/Supervising Physician (if applicable):	Name:	Phone:

3. Treatment Information

a. Please indicate requested approval period:

Weeks 6 - 12 **(week 4 labs due)** Weeks 13 - 18 Weeks 19 - 24 **(week 12 labs due)**

b. Is the patient compliant with HCV treatment? Yes No

c. Professional judgment should be used by the prescriber to determine if alcohol or drug tests are needed.

d. In the table below, specify all drug(s) being requested in the Hepatitis C regimen and indicate the total duration of the drug regimen in weeks.

Requested Drug Name(s)	Duration of drug regimen (weeks)
1.	
2.	
3.	

4. Laboratory*

Laboratory Test	Value	Date	Critical values
ALT			> 10 x ULN (400 U/L)
SCr			> 2 mg/dl
CrCl			< 30 ml/min/1.73m^2
Hgb			< 8.5 g/dl
WBC			< 1,000 cells/µL
ANC			< 500 cells/µL
Plt			< 25,000 cells/µL
HCV RNA level week 4			
HCV RNA level week 12			

**In certain cases additional labs may be requested.*

5. Signature

Provider signature: _____ Date: _____

*Provider signature indicates provider attests to all information outlined in the **Antiviral Agents for Hepatitis C Virus Prior Authorization Form, Prior Authorization Criteria and Policy,** and **Patient Education for Hepatitis C Treatment Prescriber Certification** documents.*