TEXAS Health and Human Services

Texas Vendor Drug Program

Antiviral Agents for Hepatitis C Virus Refill Authorization Request (Medicaid)

envolve Pharmacy Solutions

Please complete all fields and **fax to** *Envolve Pharmacy Solutions at* **1-866-399-0929.** Initial prior authorization requests should be completed using the ***Antiviral Agents for Hepatitis C Virus Refill Authorization Request (Medicaid)*** *(Form 1335).* ***PA must be requested every six 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 a denial.*

1. Patient Information

Name (Last, First):	Medicaid ID No.:	Date of Birth:
Gender: ◯ Male ◯ Female	Current Weight: ◯ lb ◯ kg	Therapy Start Date:

2. Prescriber Information

Prescriber Information (Accepted specialties include gastroenterology, hepatology and infectious disease)

Prescriber Name:	NPI No.:	State License No.:
Area Code and Telephone No.:	Area Code and Fax No.:	Provider Specialty:
Consulting/Supervising Physician, if applicable:	Name:	Area Code and Telephone No.:

3. Treatment Information

a. Please indicate requested approval period:

◯ Weeks 6 -12 **(week 4 labs due)** ◯ Week 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)

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
Pit			< 25,000 cells/µL
HCV RNA level week 4			
HCV RNA level week 12			

5. Signature

Provider Signature: _____ Date: _____

*Provider signature indicates provider attests to all information outlined in Parts I (**Prior Authorization Criteria**), II (**Prescriber Certification of Patient Education for Hepatitis C Treatment**), and III (**Initial Prior Authorization Request**) of Form 1335.*