

State of Oklahoma
Oklahoma Health Care Authority

Hepatitis C Therapy Continuation Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____
 Pharmacy Name: _____ Pharmacy NPI: _____
 Pharmacy Phone: _____ Pharmacy Fax: _____
 Pharmacist Name: _____ Prescriber Name: _____
 Prescriber NPI: _____ Specialty: _____
 Prescriber Phone: _____ Prescriber Fax: _____

Pharmacy Section

Member's Hepatitis C Therapy Regimen: _____

Drug Name: _____ NDC: _____
 Today's Date: _____ Date Prescription Last Filled: _____
 Date Member Took First Dose: _____ Expected End Date: _____
 Actual* Number of doses remaining today: _____ Refill Number: _____

*Do NOT estimate doses on hand

Did the member fill ribavirin? Yes ___ No ___

Date ribavirin last filled: _____ Remaining Supply: _____

Pharmacist Signature: _____ Date: _____

*By signature, the pharmacist confirms the above information is accurate.
Please do not send in chart notes. Specific information/documentation will be requested if necessary.*

Prescriber Section

Initial Viral Load _____ Date Tested: _____

Recent Viral Load _____ Date Tested: _____

Recent Urine Drug Screen? Yes ___ No ___ Date Tested: _____

Monthly Pregnancy Test?** Yes ___ No ___ NA ___ Date Tested: _____

**Required for female members and female partners of male members.

Has the member experience any adverse drug reactions related to hepatitis C therapy?

Yes ___ No ___

If yes, please specify reactions: _____

Prescriber Signature: _____ Date: _____

*By signature, the prescriber confirms the above information is accurate.
Please do not send in chart notes. Specific information/documentation will be requested if necessary.*

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

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