RI Executive Office of Health & Human Services
FEE FOR SERVICE (FFS) PRIOR AUTHORIZATION REQUEST FORM
GAINWELL TECHNOLOGIES ATTN: PHARMACIST FAX (401) 784-3889 ▪ PH (401) 784-8100

PATIENT NAME: _____ DOB: _____ MEDICAID ID NUMBER: _____

PRESCRIBER NAME: _____ NPI #: _____

OFFICE PHONE: ( ) _____ OFFICE FAX NUMBER: ( ) _____

HEPTITIS C AGENT REQUESTED: _____ WEEKS: _____

CLINICAL INFORMATION:

a. IS THIS REQUEST FOR: _____ INITIAL TREATMENT_____ RE-INFECTION _____ RE-TREATMENT

b. HEP C MEDICATION HISTORY

a. MEDICATION: _____ DOSE: _____ DATE TX INITIATED: _____ / _____ /_____ WEEKS: _____

b. MEDICATION: _____ DOSE: _____ DATE TX INITIATED: _____ / _____ /_____ WEEKS: _____

c. MEDICATION: _____ DOSE: _____ DATE TX INITIATED: _____ / _____ /_____ WEEKS: _____

c. IF PATIENT FAILED MEDICATION DESCRIBE ADVERSE DRUG EVENT: _____

_____

_____

d. OTHER RELEVANT CLINICAL INFORMATION: _____

_____

_____

e. DATE OF INITIAL DIAGNOSIS OF HEPATITIS C: _____ / _____ / _____

f. GENOTYPE: (REQUIRED FOR VOSEVI® OR NON-PREFERRED AGENTS): _____

PRESCRIBER ATTESTATION AND SIGNATURE _____ **DATE** _____

BY SIGNATURE, THE PRESCRIBER CONFIRMS S/HE IS AUTHORIZED TO PRESCRIBE THIS MEDICATION BY RI MEDICAID AND THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY CLIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST. FURTHER, PROVIDER ACKNOWLEDGES S/HE WILL PROVIDE TO EOHHS POST TREATMENT CLINICAL DATA INCLUDING VIRAL LOAD AS REQUESTED BY EOHHS.

FOR STATE USE ONLY:

APPROVAL: _____ YES _____NO PRIOR AUTHORIZATION #: _____ EFFECTIVE DATES: FROM: _____ TO _____