

# Hepatitis C Retreatment Supplemental Form

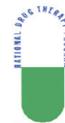
(to be completed *in addition to* the Hepatitis C Prior Authorization Form if the patient has previously been treated for hepatitis C)



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)
<input style="width: 95%;" type="text"/>				

Prescriber Name (Last)	(First)	(MI)
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Prescriber Address (Street)	(City)	(State)	(Zip)
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	West Virginia	<input style="width: 95%;" type="text"/>

Prescriber 10-Digit NPI#	Phone # (111-222-3333)	Fax # (111-222-3333)
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

Pharmacy Name (if applicable)
<input style="width: 95%;" type="text"/>

Pharmacy Address (Street)	(City)	(State)	(Zip)
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	West Virginia	<input style="width: 95%;" type="text"/>

Pharmacy 10-Digit NPI#	Phone # (111-222-3333)	Fax # (111-222-3333)
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

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**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
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>
Directions	Diagnosis	ICD Diagnosis Code (if available)
<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>

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

Date Range of Previous Treatment	Previous Medication	Previous Infection Genotype	Previous Infection SVR12 Date and Result
<input style="width: 95%;" type="text"/> / <input style="width: 95%;" type="text"/> to <input style="width: 95%;" type="text"/> / <input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/>	<input style="width: 95%;" type="text"/> / <input style="width: 95%;" type="text"/> <input style="width: 95%;" type="text"/>

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)