



**Prior Authorization Form  
Hepatitis C Agents**

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

Drug Requested (*check one*):

Incivek®

Victrelis®

Date: \_\_\_\_\_

Patient ID#: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Provider NPI: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_

Office Contact: \_\_\_\_\_

Office Fax #: \_\_\_\_\_

Office Phone: \_\_\_\_\_

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**1. DIAGNOSIS FOR DRUG REQUESTED:**

Hepatitis C genotype 1

Other (specify) \_\_\_\_\_

**2. MEDICATION HISTORY** (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

N/A If none or not applicable to diagnosis, indicate "N/A."

<b>Drug Name</b>	<b>Date</b>	<b>Duration</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**3. PATIENT HISTORY:**

a. Does the patient have compensated liver disease?

Yes

No

N/A

Please add any other supporting medical information that may be useful in the decision making process including contraindications to medications related to the diagnosis:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.**