Maryland Physicians Care
1-800-953-8854, Pharmacy Prior Authorization Prompt
Fax form to 866-207-7231

MD FFS Medicaid Hepatitis C Enhanced Management Plan

for Hepatitis C Retreatment and Therapy Restart requests

This form should accompany a fully completed Hepatitis C Prior Authorization form, medical history and supporting labs. Incomplete forms and those that do not include patient and provider signature will be returned.

Patient's Name: _____ **DOB:** _____

Prescriber's Name: _____ **Phone #:** _____

Medication Adherence: Take or use medication as directed. Do not skip a dose. If you have difficulty refilling your medication please call us right away.

Hepatitis C Treatment Regimen:

□ **Sovaldi® (sofosbuvir) 400 mg:** Take once daily for _____ weeks

□ **Olysio® (simeprevir) 150 mg:** Take once daily for _____ weeks

□ **Harvoni®:** Take_____ tablet(s) once daily for _____ weeks

□ **Viekira Pak™:** Take as directed for _____ weeks

□ **Ribavirin _____ mg:** Take _____ in the morning

and _____ in the afternoon for _____ weeks

□ **Peginterferon alfa _____ mcg:** Inject once weekly for _____ weeks

□ _____**:** Take _____daily for _____ weeks

Treatment Start Date: _____ **Treatment End Date:** _____

Laboratory Testing: Hep C viral loads must be obtained at treatment weeks 2, 4, 6, 12 and 24. (Additional 8 &10 week viral loads per provider discretion.)

Week 2:_____ **Date:** _____

Week 4: _____**Date:** _____

Week 6: _____**Date:** _____

Week 12: _____**Date:** _____

Week 24 (if indicated): _____ **Date:** _____

Special instructions:

_____

_____

The treatment plan has been discussed with the patient and the patient agrees to abide by it. The patient is aware that if this plan is not followed, it may result in cessation of Medicaid payment for current and future hepatitis C treatments.

_____ _____

Prescriber Signature **Date**

_____ _____

Patient Signature **Date**