



**Hepatitis C Virus (HCV) Medication  
Prior Authorization**

<b>Fax Completed Form to: 866-254-0761 For questions regarding this Prior authorization, call 866-773-0695</b>
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Prior Authorization Vendor for ND Medicaid
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ND Medicaid requires that patients receiving a prescription for Intron, Infergen, Pegasys, PegIntron, Incivek, or Victrelis must submit a prior authorization form.

- \*Note:**
- **Prior authorization will be granted if the requested product has been approved by the FDA for the indication listed below.**
  - **Current recommended therapy of chronic HCV infection is the combination of pegylated interferon alfa (PEGIntron or Pegasys) and ribavirin.**
  - **Incivek and Victrelis patients must be 18 years of age or older.**
  - **Incivek and Victrelis patients must also be taking ribavirin and peg-interferon.**
  - **Incivek and Victrelis will only be approved for 12 weeks for review of HCV-RNA levels and compliance.**

**Part I: TO BE COMPLETED BY PHYSICIAN**

Recipient Name		Recipient Date of Birth		Recipient Medicaid ID Number	
Physician Name					
Physician Medicaid Provider Number			Telephone Number		Fax Number
Address		City		State	Zip Code
<b>Requested Drug and Dosage:</b> <input type="checkbox"/> Intron <input type="checkbox"/> Pegasys <input type="checkbox"/> Infergen <input type="checkbox"/> PEGIntron <input type="checkbox"/> Incivek <input type="checkbox"/> Victrelis		<b>Diagnosis for this request:</b>		<b>Genotype:</b>	
		<b>Ribavirin dose:</b>			
		<b>Peg-interferon dose:</b>			
Physician Signature				Date	

**Part II: TO BE COMPLETED BY PHARMACY**

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:		
PHONE NUMBER	FAX NUMBER	DRUG	NDC #		

**Part III: FOR OFFICIAL USE ONLY**

Date Received			Initials:		
Approved - Effective dates of PA:      From:    /    /    To:    /    /			Approved by:		
Denied: (Reasons)					