MARYLAND
Department of Health and Mental Hygiene

MADAP
500 N. Calvert Street, 5th Floor
Baltimore, MD 21202
Phone: (410) 767-6535

Client Services Use Only

Date Rec'd: _____ **Insurance Review:** _____

Date Rev'd: _____ ☐ **Approved:** _____ ☐ **Denied:** _____

Elig. Date: _____ **PA Dates:** _____

PA entered: _____/_____/_____ **PA#:** _____ **Int:** _____

Fax completed form to: (410) 333-2608 or (410) 244-8696

CONTINUATION OF MADAP PRIOR AUTHORIZATION REQUEST FORM FOR HEPATITIS C THERAPY

Part 1: Patient Information

Name: _____ MADAP Client ID #: **9 4** __ __ __ __ __ __ __ __ __

DOB: _____/_____/_____ Body Weight: _____ kg Pt's Daytime Phone #: _____

What was the start date of the patient's Hepatitis C treatment regimen? _____/_____/_____

Part 2: Hepatitis C Treatment Plan and Diagnostic Update

Check the Hepatitis C treatment plan that MADAP initially approved for this patient.

☐ **Daklinza®** (daclatasvir) _____ mg:
Take once daily for _____ weeks

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

☐ **Technivie ®** (ombitasvir/paritaprevir/ritonavir) 25 mg/150 mg/ 100 mg:
Take _____ tablet(s) once daily for _____ weeks

☐ **Zepatier®** (elbasvir/grazoprevir) 50 mg/100 mg:
Take once daily for _____ weeks

☐ **Ribavirin** _____ mg: Take _____ in the morning and _____ in the afternoon for _____ weeks

☐ _____:
Take _____ as directed for _____ weeks

☐ **Harvoni®** (ledipasvir-sofosbuvir) 90 mg/400 mg:
Take _____ tablet(s) once daily for _____ weeks

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

☐ **Viekira Pak®** (dasabuvir) 250 mg + (ombitasvir/paritaprevir/ritonavir) 25 mg/150 mg/100 mg:
Take as directed for _____ weeks

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

☐ _____:
Take _____ as directed for _____ weeks

☐ _____:
Take _____ as directed for _____ weeks

Complete the following information for this patient.

What is the patient's HCV genotype and subtype? _____

What is the patient's quantitative HCV RNA after 4 weeks of treatment? _____ IU/mL

Test date: _____/_____/_____

Did any interruption(s) occur in the patient's Hepatitis C treatment plan after MADAP approval? ☐ No ☐ Yes

If yes, state the date(s), cause(s) and/or outcome(s) of any interruption(s) in the patient's Hepatitis C treatment plan:

_____

_____

The prescribing clinician is requesting continuation of the patient's Hepatitis C treatment plan. ☐ No ☐ Yes

If no, state the date and reason(s) that the patient's Hepatitis C treatment plan was/will be discontinued:

_____

_____

If yes, what is the expected Hepatitis C treatment end date? _____/_____/_____

Part 3: HIV Treatment Status

Has the patient been on HIV anti-retroviral therapy since starting Hepatitis C treatment? ☐ No ☐ Yes

Is the patient expected to take HIV medications during continued Hepatitis C treatment? ☐ No ☐ Yes

If No, state reason: _____

If Yes, list the ART being prescribed: _____

Part 4: Precautions and Adherence Monitoring

Will precautions and adherence monitoring continue during the course of HCV treatment? ☐ No ☐ Yes

Please describe any special precautions and/or adherence issues that were reviewed with the patient:

_____

_____

Part 5: Patient Assistance Affidavit

Is the prescribing clinician prepared to have the patient enrolled in other patient assistant drug programs to complete the Hepatitis C therapy, if MADAP has approved the HCV regimen, but the patient subsequently becomes ineligible for MADAP coverage? ☐ No ☐ Yes

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescribing Clinician: _____ License No. & State: _____

Clinic/Hospital Name: _____ NPI #: _____

Street Address: _____ Phone #: _____

City, State & Zip: _____ Fax #: _____

Clinician's Signature: _____ Date: _____/_____/_____