AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Hepatitis C Treatments

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:	Patient name:	
Patient address:		DOB:
Provider NPI:	Prescriber name:	Phone:
Prescriber address:		Fax:
Pharmacy name:		
Address:		Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI:	Pharmacy fax:	NDC:

Prior authorization (PA) is required for hepatitis C treatments. Requests for non-preferred agents may be considered when documented evidence is provided that the use of the preferred agents would be medically contraindicated. Payment will be considered under the following conditions: 1) Patient is 18 years of age or older and has a diagnosis of chronic hepatitis C; and 2) Patient has had testing for hepatitis C virus (HCV) genotype; and 3) Patient has an active HCV infection verified by a detectable viral load within 12 months of starting treatment; and 4) Patient has been tested for hepatitis B (HBV) prior to initiating treatment of HCV and individuals with active HBV infection are treated (either at same time as HCV therapy or before HCV therapy is started); and 5) Viral load will be submitted by the prescriber 12 weeks after the completion of therapy; and 6) Patient has advanced liver disease corresponding to a Metavir score of 3 or greater fibrosis as confirmed by one of the following: a) liver biopsy confirming a Metavir score ≥3; or b) transient elastography (FibroScan) score ≥ 9.5kPa; or c) FibroSURE (FibroTest) score ≥0.58; or d) APRI score >1.5; or e) radiological imaging consistent with cirrhosis (i.e., evidence of portal hypertension); or f) physical findings or clinical evidence consistent with cirrhosis; or g) patients at highest risk for severe complications: organ transplant, type 2 or 3 essential mixed cryoglobulinemia with end-organ manifestations (e.g. vasculitis), proteinuria, nephrotic syndrome, or membranoproliferative glomerulonephritis; and 7) Patient's prior treatment history is provided (treatment naïve or treatment experienced); and 8) If patient has a history of non-compliance, documentation that steps have been taken to correct or address the causes of non-compliance are provided; and 9) Patient has abstained from the use of illicit drugs and alcohol for a minimum of three (3) months as evidenced by a negative urine confirmation test; and 10) For regimens containing sofosbuvir (Sovaldi/Harvoni/Epclusa), patient does not have severe renal impairment (creatinine clearance <30ml/min) or end stage renal disease requiring hemodialysis; and 11) HCV treatment is prescribed by a digestive disease, liver disease, or infectious disease provider practice; and 12) For patients on a regimen containing ribavirin, documentation of the following on the PA form: a) Patient is not a pregnant female or a male with a pregnant female partner; and b) Women of childbearing potential and their male partners must use two forms of effective contraception during treatment and for at least 6 months after treatment has concluded; and c) Monthly pregnancy tests will be performed during treatment; and 13) Prescriber has reviewed the patient's current medication list and acknowledged that there are no significant drug interactions with the HCV medication; and 14) Documentation is provided for patients who are ineligible to receive ribavirin. 15) Non-FDA approved or non-compendia indicated combination therapy regimens will not be approved. 16) If patient is recently eligible for Iowa Medicaid, and has been started and stabilized on therapy while covered under a different plan, documentation of how long the patient has been on medication will be required. Patient will be eligible for the remainder of therapy needed, based on established length of therapy for the particular treatment (defined below). 17) Lost or stolen medication replacement requests will not be authorized. 18) The 72-hour emergency supply rule does not apply to hepatitis C treatments.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Preferred:			Non-Preferred:
☐ Epclusa	☐ Viekira Pak	☐ Zepatier	☐ Olysio
☐ Harvoni	☐ Viekira XR		☐ Daklinza
☐ Sovaldi	☐ Technivie		

Instructions for completing the Hepatitis C Treatments PA form:

Section 1 of the PA form lists the various regimens and clinical situations for which hepatitis C treatments will be considered medically necessary according to Iowa Medicaid PA criteria. Section 2 includes additional supporting documentation that is required on the PA form.

- Check ONE box in Section 1 – Treatment Regimen.
- Review and complete each numbered item in Section 2 – Supporting Documentation.
- Attach lab results, chart notes, and other documentation; sign, and fax the completed form to 1-855-825-2714.

Section 1 – Treatment Regimen

Check ONE box below to indicate the requested treatment regimen based on the patient's genotype, treatment history, and extent of liver disease.

Genotype 1 (Note: the subtype is listed if there are differences in the recommended treatments)

Treatment naïve, no cirrhosis, HCV viral load < 6 million copies/ml

☐ Harvoni 90/400 mg daily for 8 weeks (HIV negative only)

☐ Harvoni 90/400 mg daily for 12 weeks

☐ 1a: Viekira Pak (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets AM and dasabuvir 250 mg BID) or Viekira XR (dasabuvir, ombitasvir, paritaprevir, and ritonavir 200/8.33/50/33.33 mg three tablets once daily) plus weight-based ribavirin for 12 weeks

☐ 1a: Zepatier for 12 weeks in patients without baseline NS5A polymorphisms

☐ 1b: Viekira Pak (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets AM and dasabuvir 250 mg BID) or Viekira XR (dasabuvir, ombitasvir, paritaprevir, and ritonavir 200/8.33/50/33.33 mg three tablets once daily) for 12 weeks

☐ 1b: Zepatier for 12 weeks

Treatment naïve, no cirrhosis, HCV viral load ≥ 6 million

☐ Harvoni 90/400 mg daily for 12 weeks

☐ 1a: Viekira Pak (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets AM and dasabuvir 250 mg BID) or Viekira XR (dasabuvir, ombitasvir, paritaprevir, and ritonavir 200/8.33/50/33.33 mg three tablets once daily) plus weight-based ribavirin for 12 weeks

☐ 1a: Zepatier for 12 weeks in patients without baseline NS5A polymorphisms

☐ 1b: Viekira Pak (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets AM and dasabuvir 250 mg BID) or Viekira XR (dasabuvir, ombitasvir, paritaprevir, and ritonavir 200/8.33/50/33.33 mg three tablets once daily) for 12 weeks

☐ 1b: Zepatier for 12 weeks

Treatment naïve, compensated cirrhosis

☐ Harvoni 90/400 mg daily for 12 weeks

☐ 1b: Viekira Pak (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets AM and dasabuvir 250 mg BID) or Viekira XR (dasabuvir, ombitasvir, paritaprevir, and ritonavir 200/8.33/50/33.33 mg three tablets once daily) for 12 weeks (Child-Pugh (CP) A ONLY, contraindicated for CP B or C)

☐ 1a: Zepatier for 12 weeks in patients without baseline NS5A polymorphisms

☐ 1a: Viekira Pak (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets AM and dasabuvir 250 mg BID) or Viekira XR (dasabuvir, ombitasvir, paritaprevir, and ritonavir 200/8.33/50/33.33 mg three tablets once daily) plus weight-based ribavirin for 24 weeks (Child-Pugh (CP) A ONLY, contraindicated for CP B or C)

☐ 1b: Zepatier for 12 weeks

Treatment experienced (PEG-IFN/RBV ONLY), no cirrhosis

☐ Harvoni 90/400 mg daily for 12 weeks

☐ 1a: Viekira Pak (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets AM and dasabuvir 250 mg BID) or Viekira XR (dasabuvir, ombitasvir, paritaprevir, and ritonavir 200/8.33/50/33.33 mg three tablets once daily) plus weight-based ribavirin for 12 weeks

☐ 1a: Zepatier for 12 weeks in patients without baseline NS5A polymorphisms

☐ 1b: Viekira Pak (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets AM and dasabuvir 250 mg BID) or Viekira XR (dasabuvir, ombitasvir, paritaprevir, and ritonavir 200/8.33/50/33.33 mg three tablets once daily) for 12 weeks

☐ 1b: Zepatier for 12 weeks

Treatment experienced (PEG-IFN/RBV ONLY), cirrhosis

☐ Harvoni 90/400 mg daily for 24 weeks (will be approved only for patients with documented ineligibility for ribavirin¶)

☐ Harvoni 90/400 mg daily plus weight-based ribavirin for 12 weeks

☐ 1a: Viekira Pak (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets AM and dasabuvir 250 mg BID) or Viekira XR (dasabuvir, ombitasvir, paritaprevir, and ritonavir 200/8.33/50/33.33 mg three tablets once daily) plus weight-based ribavirin for 24 weeks (Child-Pugh (CP) A ONLY, contraindicated for CP B or C)

☐ 1a: Zepatier for 12 weeks in patients without baseline NS5A polymorphisms

☐ 1b: Viekira Pak (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets AM and dasabuvir 250 mg BID) for 12 weeks (Child-Pugh (CP) A ONLY, contraindicated for CP B or C)

☐ 1b: Zepatier for 12 weeks

Treatment experienced (PEG-IFN/RBV+PI), no cirrhosis

☐ Harvoni 90/400 mg daily for 12 weeks

☐ 1a: Zepatier plus weight-based RBV for 12 weeks in patients without baseline NS5A polymorphisms

☐ 1b: Zepatier plus weight-based RBV for 12 weeks

Treatment experienced (PEG-IFN/RBV±PI), compensated cirrhosis

☐ Harvoni 90/400 mg daily for 24 weeks (will be approved only for patients with documented ineligibility for ribavirin¶)

☐ Harvoni 90/400 mg daily plus weight-based ribavirin for 12 weeks

☐ 1a: Zepatier plus weight-based RBV for 12 weeks in patients without baseline NS5A polymorphisms

☐ 1b: Zepatier plus weight-based RBV for 12 weeks

Treatment experienced (sofosbuvir + ribavirin +/- PEG-IFN), no cirrhosis

☐ Harvoni 90/400 mg daily plus weight-based ribavirin for 12 weeks

Treatment experienced (sofosbuvir + ribavirin +/- PEG-IFN), compensated cirrhosis

☐ Harvoni 90/400 mg daily plus weight-based ribavirin for 24 weeks

Treatment experienced (sofosbuvir + simeprevir), no cirrhosis

☐ Guidelines recommend awaiting new data to guide treatment

Treatment experienced (sofosbuvir + simeprevir), cirrhosis

☐ Testing for resistance-associated variants that confer decreased susceptibility to NS3 protease inhibitors and to NS5A inhibitors is recommended which choice of agents based on this testing with planned duration of 24 weeks with RBV unless contraindicated

Treatment experienced (prior treatment with any NS5A inhibitor (daclatasvir + sofosbuvir, ledipasvir + sofosbuvir or paritaprevir/ritonavir/ombitasvir + dasabuvir), no cirrhosis

☐ Guidelines recommend awaiting new data to guide treatment

Treatment experienced (prior treatment with any NS5A inhibitor (daclatasvir + sofosbuvir, ledipasvir + sofosbuvir or paritaprevir/ritonavir/ombitasvir + dasabuvir), cirrhosis or urgent need for treatment

☐ Testing for resistance-associated variants that confer decreased susceptibility to NS3 protease inhibitors and to NS5A inhibitors is recommended. Choice of agents should be based on this testing with a planned duration of 24 weeks with RBV unless contraindicated

Re-infection of allograft liver after transplant

☐ Harvoni 90/400 mg daily plus weight-based ribavirin for 12 weeks

☐ Harvoni 90/400 mg daily for 24 weeks (will be approved only for patients with documented ineligibility for ribavirin¶)

Decompensated cirrhosis, no prior sofosbuvir, including those with hepatocellular carcinoma who may or may not be candidates for liver transplantation

☐ Harvoni 90/400 mg daily plus low dose ribavirin# for 12 weeks

☐ Daklinza 60 mgˆ daily plus Sovaldi 400mg daily for 24 weeks (will be approved only for patients with documented ineligibility for ribavirin¶)

Decompensated cirrhosis, prior treatment with sofosbuvir

☐ Harvoni 90/400 mg daily + low dose ribavirin# for 24 weeks

Recurrent HCV infection post-liver transplantation

☐ Harvoni 90/400 mg daily plus weight-based ribavirin for 12 weeks

☐ Harvoni 90/400 mg daily for 24 weeks (will be approved only for patients with documented ineligibility for ribavirin¶)

Recurrent HCV infection post-liver transplantation, decompensated cirrhosis

☐ Harvoni 90/400 mg daily plus low dose ribavirin# for 12 weeks

Genotype 2

Treatment naïve, no cirrhosis

☐ Epclusa 400/100 mg daily for 12 weeks

Treatment naïve, compensated cirrhosis

☐ Epclusa 400/100 mg daily for 12 weeks

Treatment experienced (PEG-IFN + ribavirin), with or without cirrhosis

☐ Epclusa 400/100 mg daily for 12 weeks

Treatment experienced (sofosbuvir + ribavirin)

☐ Epclusa 400/100 mg daily plus weight-based ribavirin for 12 weeks

☐ Daklinza 60 mgˆ daily plus Sovaldi 400 mg daily for 24 weeks (will be approved only for patients with documented ineligibility for ribavirin¶)

Decompensated cirrhosis

☐ Epclusa 400/100 mg daily + weight-based ribavirin for 12 weeks

Recurrent HCV infection post-liver transplantation, no or compensated cirrhosis

☐ Daklinza 60 mgˆ daily plus Sovaldi 400mg daily plus low dose ribavirin# for 12 weeks

☐ Daklinza 60 mgˆ daily plus Sovaldi 400mg daily for 24 weeks (will be approved only for patients with documented ineligibility for ribavirin¶)

Recurrent HCV infection post-liver transplantation, decompensated cirrhosis

☐ Sovaldi 400 mg daily plus low dose ribavirin# for 24 weeks

Genotype 3

Treatment naive, with or without cirrhosis

☐ Epclusa 400/100 mg daily for 12 weeks

Treatment experienced (PEG-IFN + ribavirin), no cirrhosis

☐ Epclusa 400/100 mg daily for 12 weeks

Treatment experienced (PEG-IFN + ribavirin), compensated cirrhosis

☐ Epclusa 400/100 mg plus weight-based ribavirin daily for 12 weeks

Treatment experienced (sofosbuvir + ribavirin), no or compensated cirrhosis

☐ Epclusa 400/100 mg plus weight-based ribavirin daily for 12 weeks

Decompensated cirrhosis

☐ Epclusa 400/100 mg plus weight-based ribavirin daily for 12 weeks

Recurrent HCV infection post-liver transplantation, no or compensated cirrhosis

☐ Daklinza 60 mgˆ daily plus Sovaldi 400mg daily plus low dose ribavirin# for 12 weeks

☐ Daklinza 60 mgˆ daily plus Sovaldi 400mg daily for 24 weeks (will be approved only for patients with documented ineligibility for ribavirin¶)

Genotype 4

Treatment naïve, no cirrhosis

☐ Harvoni 90/400 mg daily for 12 weeks

☐ Technivie (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets daily) plus weight-based ribavirin for 12 weeks

☐ Zepatier for 12 weeks

Treatment naïve, compensated cirrhosis

☐ Harvoni 90/400 mg daily for 12 weeks

☐ Technivie (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets daily) plus weight-based ribavirin for 12 weeks

☐ Zepatier for 12 weeks

Treatment experienced (PEG-IFN/RBV ONLY), no cirrhosis

☐ Harvoni 90/400 mg daily for 12 weeks

☐ Technivie (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets daily) plus weight-based ribavirin for 12 weeks

☐ Zepatier for 12 weeks if prior virologic relapse

☐ Zepatier plus weight-based RBV for 16 weeks for patients with prior on-treatment virologic failure (failure to suppress or breakthrough)

Treatment experienced (PEG-IFN/RBV ONLY), compensated cirrhosis

☐ Harvoni 90/400 mg plus weight-based ribavirin daily for 12 weeks

☐ Technivie (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg two tablets daily) plus weight-based ribavirin for 12 weeks

☐ Zepatier for 12 weeks if prior virologic relapse

☐ Zepatier plus weight-based RBV for 16 weeks for patients with prior on-treatment virologic failure (failure to suppress or breakthrough)

Decompensated cirrhosis

☐ Harvoni 90/400 mg daily plus low dose ribavirin# for 12 weeks

☐ Harvoni 90/400 mg daily for 24 weeks (will be approved only for patients with documented ineligibility for ribavirin¶)

Decompensated cirrhosis, prior treatment with sofosbuvir

☐ Harvoni 90/400 mg daily plus low dose ribavirin# for 24 weeks

Recurrent HCV infection post-liver transplantation, no or compensated cirrhosis

☐ Harvoni 90/400 mg daily plus weight-based ribavirin for 12 weeks

☐ Harvoni 90/400 mg daily for 24 weeks (will be approved only for patients with documented ineligibility for ribavirin¶)

Recurrent HCV infection post-liver transplantation, decompensated cirrhosis

☐ Harvoni 90/400 mg daily plus low dose ribavirin# for 12 weeks

Genotype 5

Regardless of prior treatment or cirrhosis

☐ Harvoni 90/400 mg daily for 12 weeks

Genotype 6

Regardless of prior treatment or cirrhosis

☐ Harvoni 90/400 mg daily for 84 days (12 weeks)

Other Treatment Regimen

Genotype, treatment history, and extent of liver disease:

Drug name/regimen, dose and duration:

Clinical rationale for selecting regimens other than those outlined above:

Abbreviations: PEG-IFN = peg-interferon; RBV = ribavirin; PI = protease inhibitor

low dose ribavirin = 600 mg/day and increase as tolerated

ˆ Dose of Daklinza (daclatasvir) MUST BE ADJUSTED with certain co-administered drugs (reduced to 30 mg daily with concurrent CYP3A4 inhibitors and increased to 90 mg daily with concurrent moderate CYP3A4 inducers)

Section 2 – Supporting Documentation

Review and complete each numbered item below to provide the supporting documentation for the PA request.

Diagnosis:

1. Pretreatment viral load (attach results): Date obtained:

2. Documentation of advanced liver disease (attach results): Date obtained:

☐ Liver biopsy confirming a Metavir score ≥ F3

☐ Transient elastography (FibroScan) score ≥ 9.5kPa

☐ FibroSURE (FibroTest) score ≥ 0.58

☐ APRI score > 1.5

☐ Radiological imaging consistent with cirrhosis
(i.e. evidence of portal hypertension)

☐ Physical findings or clinical evidence consistent with cirrhosis

☐ Patients at highest risk for severe complications: organ transplant, type 2 or 3 essential mixed cryoglobulinemia with end-organ manifestations (e.g. vasculitis), proteinuria, nephrotic syndrome, or membranoproliferative glomerulonephritis.

Patient History:

3. Does the patient have a history of non-compliance? ☐ Yes ☐ No
If yes, submit chart notes documenting the steps taken to correct or address the non-compliance (attach chart notes)

4. ☐ Documentation in provider notes (must be submitted) showing that member has had no abuse of alcohol and drugs for the previous 3 months.

☐ MUST submit urine drug screen for members with history of abuse of drugs other than alcohol.

☐ Counseling MUST be provided and documented regarding non-abuse of alcohol and drugs as well as education on how to prevent HCV transmission.

5. Is the patient receiving dialysis? ☐ Yes ☐ No

6. Is the patient's creatinine clearance ≥30 ml/min? ☐ Yes ☐ No

7. Has patient been screened for hepatitis B? ☐ Yes ☐ No Date: _____
Active disease: ☐ Yes ☐ No If yes, has patient been treated or currently being treated? ☐ Yes ☐ No

Prescriber Information:

8. Provider practice: ☐ Digestive disease ☐ Liver disease ☐ Infectious disease

Regimens Containing Ribavirin:

9. If the patient is female and of childbearing potential, or the patient is male with a female partner of childbearing potential, the prescriber must acknowledge the following:

☐ The patient is not pregnant (or a male patient with a pregnant female partner) and is not planning to become pregnant during treatment or within 6 months of stopping treatment.

☐ Both partners will use two forms of effective contraception during treatment and for at least 6 months after stopping treatment.

☐ Monthly pregnancy tests will be performed throughout treatment.

10. Complete blood count with differential (attach results)

11. If the patient is ineligible for ribavirin¶, select the appropriate reason from the list below:

☐ History of severe or unstable cardiac disease	☐ Baseline platelets <70,000 cells/μL
☐ Pregnant women and men with pregnant partners	☐ Baseline absolute neutrophil count <1,500 cells/μL
☐ Diagnosis of hemoglobinopathy (e.g., thalassemia major, sickle cell anemia)	☐ Baseline hemoglobin <12 g/dL in women or <13 g/dL in men
☐ Hypersensitivity to ribavirin	☐ Other:

Note: Laboratory values will be reviewed and requests will not be considered if labs are outside of a specific range. Patients with CrCl <50 ml/min (moderate or severe renal dysfunction, ESRD, HD) should have dosage reduced.

Potentially Significant Drug Interactions:

12. Coadministration of hepatitis C treatments with the following medications is not recommended. By checking one of the following boxes, the prescriber attests that they have reviewed the patient's medications for potentially significant drug interactions with the hepatitis C treatment. If the medication list contains one or more of the following medications, the medication(s) will be changed to another agent.

    ☐ Harvoni: The patient's current medication list does NOT include: carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifabutin, rifampin, rifapentine, St. John's Wort, ritonavir, tipranavir, Stribild, rosuvastatin, H2-receptor antagonists above the following daily doses: famotidine 80 mg, ranitidine/nizatidine 600 mg or cimetidine 1600 mg; or proton-pump inhibitors above the following daily doses: esomeprazole 20 mg, lansoprazole or 30 mg, dexlansoprazole 60 mg, omeprazole 20 mg, pantoprazole 40 mg, rabeprazole 20 mg

    ☐ Sovaldi: The patient's current medication list does NOT include: carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifabutin, rifampin, rifapentine, St. John's Wort, or tipranavir/ritonavir

    ☐ Viekira Pak/Viekira XR/Technivie: The patient's current medication list does NOT include: strong inducers of CYP3A/2C8, alfuzosin, carbamazepine, phenytoin, phenobarbital, gemfibrozil, rifampin, ergotamine, dihydroergotamine, ergonovine, methylergonovine, ethinyl estradiol-containing medications, St. John's Wort, lovastatin, simvastatin, pimozide, efavirenz, sildenafil, traizolam, or midazolam

    ☐ Olysio: The patient's current medication list does NOT include significant drug interactions. Consult the full prescribing information for potential drug interactions.

    ☐ Daklinza: The patient's current medication list does NOT include significant drug interactions or dose is adjusted appropriately. Consult the full prescribing information for potential drug interactions including MANY that require dosage adjustment.

    ☐ Zepatier: The patient's current medication list does NOT include significant drug interactions. Consult the full prescribing information for potential drug interactions.

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.