ILLINOIS DEPARTMENT OF PUBLIC HEALTH
IDPH
PROTECTING HEALTH, IMPROVING LIVES

Ryan White Part B ADAP Medication Assistance Program (MAP)
Application for Pre Approval of Hepatitis C Medication Assistance

The following medications are now available with pre approval through the Medication Assistance Program
(click on the name to take you directly to the specific Prescribing Guidelines)

Harvoni **Viekira Pak** **ribavirin** **Sovaldi** **Zepatier** **Technivie** **Daklinza**

List ALL Current Medications (Rx and Over the counter):_____

_____

To be eligible for assistance with these medications, a client must:

- Be currently enrolled in MAP and eligible for MAP assistance for the full duration of treatment.
- Be a patient who has Fibrosis Stage 1 (F1) and above

Complete the following:

Applicant's Name_____
Legal First Middle Last

Social Security Number _____ **Date of Birth** _____

Address _____

City _____ **State** _____ **ZIP Code** _____

Baseline HCV RNA: _____ **HCV Genotype:** _____ **(documentation required)**
(For Zepatier: If Genotype 1a – Need baseline NS5A resistance test and documentation)

Hepatitis C Treatment History: ☐ Treatment Naïve ☐ Treatment Experienced

Fibrosis Staging: ☐ Fibroscan score (> 7.1) ☐ Fibrotest ☐ Liver Biopsy showing F1 and above **(documentation required)**

Physician Name: (Print) _____ **Clinic:** _____

Phone Number: _____ **Fax Number:** _____

Prescription Information:

Medication (mark all that apply): **Harvoni** ☐ **Viekira Pak** ☐ **ribavirin** ☐ **Sovaldi** ☐ **Zepatier** ☐ **Technivie** ☐ **Daklinza** ☐

Number of Weeks (Mark one): ◯ **12 weeks** ◯ **16 weeks** ◯ **24 weeks**

Provider Signature:_____

Provider must acknowledge the following with initials:

_____ I have reviewed the prescribing guidelines for possible interactions and issues of the medication regimen I am prescribing.

_____ HCV RNA should be monitored before therapy, at week 4, end of therapy and 12 weeks post treatment completion

_____ Patient has been counseled on the high cost of treatment and is willing to be 100% adherent to treatment regimen

Submit to: Illinois Department of Public Health **or** Fax to: 217-785-8013
525 W. Jefferson St., 1st Floor, Springfield, IL 62761

IDPH USE ONLY: Authorization Approved? ❑ YES ❑ NO Authorization Number: _____

Authorization Effective Date: _____ Authorization Expiration Date: _____