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** **Epclusa**

**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** ☐ **Epclusa** ☐ **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
525 W. Jefferson St., 1st Floor, Springfield, IL 62761

**or** Fax to: 217-785-8013

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

Authorization Effective Date: _____ Authorization Expiration Date: _____

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