

**Return Completed Form to:**  
MADAP  
500 N. Calvert Street, 5th Floor  
Baltimore, MD 21202  
Confidential Fax: (410) 333-2608  
Phone: (410) 767-6535

MADAP Office Use Only	
Date Received: _____	MADAP Exp.: _____
Authorized: Yes ___ No ___	Initials: _____
Updated in System: Yes ___ No ___	
Initial Date of MADAP support of HCV tx : _____	

**Continued MADAP approval of peginterferon alfa 2a or 2b & oral ribavirin**

Client Name \_\_\_\_\_ MADAP ID Number: 94

**NOTE:** This form must be completed for all clients whose treatment with the requested drugs has been ongoing for 90 or more days, regardless of payer. MADAP will pay for one course of treatment, or a portion thereof, not to exceed 48 weeks beginning with the initiation of treatment. The results of the 180day/24 week RNA levels will determine if MADAP will pay for treatment after 24 weeks. MADAP coverage begins the month of an approved request. MADAP coverage ends at 24 weeks (depending on RNA levels) or 48 weeks from the initiation of treatment.

1. **Requesting continuation of coverage for ribavirin and peginterferon:** \_\_\_ alfa 2a or \_\_\_ alfa 2b
2. **Date treatment began:** \_\_\_\_\_
3. **Continuation request for treatment interval of: ( Please put dates for the period you are requesting at this time below.)**  
90 Days (12weeks) \_\_\_\_\_ 180 Days (24 weeks)\* \_\_\_\_\_ 270 Days (36 weeks) \_\_\_\_\_

\* If treatment has been ongoing for 180 Days/24 weeks, are HCV RNA levels at 24 weeks:  
Detectable? \_\_\_ Undetectable? \_\_\_ Supporting Laboratory Reports Must Be Submitted

4. **Intend to continue treatment?** Yes \_\_\_\_\_ No \_\_\_\_\_  
**If answer to question 3 is "No", then treatment discontinuation is due to: Check One**
  - Positive or detectable HCV RNA at 24 weeks of therapy
  - Intractable thrombocytopenia
  - Depression; not responsive to treatment
  - Side effects of medical condition
  - Not listed, please describe: \_\_\_\_\_
  - Profound anemia or leukopenia; not responsive to cytokine support
  - Myositis
  - Unusual side effect such as auto-immune hypothyroidism
  - Patient non-compliance or request

4. **Client Side Effects:** Please note the degree of client reported discomfort due to peginterferon alfa 2a or 2b & ribavirin treatment.

1	2	3	4
None	Minimal	Moderate	Severe

5. **Is client continuing/resuming HIV treatment?** Yes \_\_\_\_\_ No \_\_\_\_\_

Clinician Name \_\_\_\_\_ Date \_\_\_\_\_ DEA # \_\_\_\_\_

Address \_\_\_\_\_ License # & State \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Clinician Signature \_\_\_\_\_