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Hepatitis C Medication Request Form

This form **can** be used to request:

- Hepatitis C Antivirals (e.g. Daklinza, Epclusa, Harvoni, Olysio, Sovaldi, Technivie, Viekira Pak, Zepatier)

Patient Information		Prescriber Information		
Patient Name:		Prescriber Name:		
Member ID#		DEA#	NPI#	
Address:		Address:		
City:	State	City:		State:
Home Phone:	Zip:	Office Phone:	Office Fax:	Zip:
Sex: M F	DOB:	Contact Person:		

Diagnosis and Medical Information			
Medication:	Directions for use: (Frequency & Strength):		
☐ New Prescription OR Date Therapy Initiated**:**	Expected Length of Therapy: Route of Administration:		Qty: Qty per month:
Height/Weight:	Drug Allergies:	Diagnosis:	
Prescriber's Signature:	MD Specialty		Date:

Rationale for Exception Request or Prior Authorization
FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

Documentation of Medical Necessity (please be specific):

1. Does the patient have chronic hepatitis C (i.e. diagnosis for a minimum of 6 months)? ☐ Yes ☐ No

   Date initially diagnosed: ________________ Please provide documentation with date of initial diagnosis.
2. Please indicate hepatitis C genotype: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
3. Is the patient of African descent ? ☐ Yes ☐ No
4. Is the patient at least 18 years old **OR** is 12-17 years old **OR** weighs at least 77 pounds (35kg) ☐ Yes ☐ No
5. Is the requested medication being prescribed by a gastroenterologist, infectious disease specialist, or hepatologist? ☐ Yes ☐ No
6. Has an invasive or non-invasive test been done to stage the patient's liver disease within the past 3 years? ☐ Yes ☐ No

   If yes, please indicate the testing method and result AND provide documentation of result.

   ☐ METAVIR score: ________ ☐ Fibroscan score: _________________ ☐ FibroSURE score: ________ ☐ APRI score: ________
   ☐ Radiological imaging: _______ ☐ Other: _________________________ Date of test: ____________

(Continues next page)

7. Does the patient have cirrhosis? ☐ Yes ☐ No
If yes, is it compensated or decompensated cirrhosis? ☐ compensated ☐ decompensated

8. What is the patient's pre-treatment HCV RNA level (within the last 6 months)?
Date of test: _____________Result: ______________________ Please provide documentation of result.

9. Has the patient been treated previously for Hepatitis C? ☐ Yes (treatment-experienced) ☐ No (treatment-naïve)
If yes, please list previous treatment regimens [please include concurrent use of PEG-IFN (interferon) or RBV (ribavirin)].
Medications: ____ Dates: ____________________________
Medications: ____ Dates: ____________________________

10. Will the requested medication be used in combination with ribavirin? ☐ Yes ☐ No
11. Does the patient have a contraindication to Mavyret **AND** Zepatier? ☐ Yes ☐ No
12. Is the patient currently participating in illicit substance abuse or alcohol abuse? ☐ Yes ☐ No
If yes, is the patient receiving substance or alcohol abuse counseling services as an adjunct to HCV treatment? ☐ Yes ☐ No

13. Does the patient have severe renal disease? ☐ Yes ☐ No
If yes, please provide details: ☐ ESRD ☐ Creatinine clearance (CrCl): __________ mL/min R
Is the member currently receiving dialysis? ☐ Yes ☐ No
14. Has the patient received prior treatment (e.g., treatment-experienced patient) for hepatitis C with 1) peginterferon and ribavirin, 2) triple therapy with HCV protease inhibitor, peginterferon and ribavirin **OR** 3) is the patient without cirrhosis with a prior regimen of Sovaldi/ribavirin with or without peginterferon? ☐ Yes ☐ No
15. Does the patient have a history of a liver transplant? ☐ Yes ☐ No
16. Has the provider attested they have reviewed for drug interactions that are contraindicated or may reduce the efficacy of the requested medication? ☐ Yes ☐ No

For Harvoni, Epclusa, Viekira and Vosevi requests, has the patient been counseled regarding the potential for antacids, H2 blockers and proton pump inhibitors, including over-the-counter (OTC) medications that decrease efficacy? ☐ Yes ☐ No

For patients with HIV co-infection

1. Is the patient co-infected with HIV? ☐ Yes ☐ No
2. Is the HIV infection controlled on medication (HIV viral load less than 200 copies per mL within the past 6 months)? ☐ Yes ☐ No
If yes, please provide the patient's current HIV treatment regimen:____
3. Is the patient's antiretroviral regimen being managed by a physician specializing in the treatment of HIV? ☐ Yes ☐ No

For Daklinza (daclatasvir)

1. Will the requested medication be taken in combination with Sovaldi (sofosbuvir)? ☐ Yes ☐ No

For Zepatier (elbasvir/grazoprevir)

1. If genotype 1a or 1 with mixed or unknown subtypes, has the patient been tested for the presence of virus with NS5A resistance-associate polymorphisms? ☐ Yes ☐ No
If yes, does the patient have NS5A polymorphisms at baseline? ☐ Yes ☐ No

For Sovaldi (sofosbuvir)

1. Will Sovaldi be used in combination with Daklinza or Olysio? ☐ Yes ☐ No
If yes, please indicate which medication: ☐ Daklinza ☐ Olysio

Additional information pertinent to this request:____
____
____
____

Important: In addition to this Medication Request Form, please include documentation of a confirmed diagnosis of chronic Hepatitis C for at least 6 months (requested in #1), the liver disease staging result (requested in #7), results of the HCV RNA viral load (requested in #9), and if applicable, a copy of the HIV vial load dated within the past 6 months.

Request for Expedited Review

☐ REQUEST FOR EXPEDITED REVIEW [24 HOURS]

- BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Information on this form is protected Health Information and subject to all privacy and security regulations under HIPAA.