Alabama Medicaid Pharmacy
Hepatitis C Antiviral Agents PA Request Form

FAX: (800) 748-0116   **Fax or Mail**   **P.O. Box 3210**
Phone: (800) 748-0130   HEALTH INFORMATION   **Auburn, AL 36831-3210**

PATIENT INFORMATION

Patient Name_____ Patient Medicaid # _____

Patient DOB_____ Patient phone # with area code_____

PRESCRIBER INFORMATION

Prescriber name_____ NPI #_____ License #_____

Phone # with area code_____ Fax # with area code_____

Address (Optional)_____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

_____
Prescribing Practitioner Signature   **Date**

DRUG/CLINICAL INFORMATION

Drug Code_____ Quantity _____ Day's supply _____

Diagnosis or ICD-9/ICD-10 Code_____ Scheduled start date of therapy _____

Please include applicable diagnostic measures for liver disease below:
- Metavir Fibrosis Score _____
- AST to Platelet Ratio Index (APRI) _____
- Child-Turcotte-Pugh (CTP) classification _____
- Fibroscan value _____ kilopascals
- Acoustic Radiation Force Impulse Image (ARFI) _____m/sec
- Fibrosis-4 (FIB-4) Score_____
- Abdominal imaging (ultrasound, CT, MRI) results (check all that apply):
  - □ Surface abnormalities (e.g. nodularity, left lobe/caudate lobe hypertrophy)
  - □ Features of portal hypertension (e.g. splenomegaly, recanalization of umbilical vein, collaterals)
  - □ Ascites   *SVR rates are required at 12 **or** 24 weeks post therapy for approved requests

Please include patient specific questions below for ALL requests:
- Has the patient previously completed **or** started and discontinued one of the regimens for Hepatitis C included on this form? If yes, which regimen?_____ □ Yes □ No
- Is the patient HIV co-infected?   □ Yes □ No □ Unknown
  - If yes, has the patient been on a stable regimen of HIV medications for at least 8 weeks?   □ Yes □ No
  - Include: Viral load _____copies/ml **and** CD4 count _____cells/mm³
- Has the patient used alcohol or illicit drugs within the last 6 months? (a copy of the patient's drug and alcohol screening lab report must be submitted with the request)   □ Yes □ No
- Has the patient been counseled on the proposed regimen to include possible side effects that may occur?   □ Yes □ No
- Has the patient been informed of Alabama Medicaid's policy to only approve 1 treatment regimen with one of the hepatitis C products included on this form per lifetime?   □ Yes □ No
- Has the patient been informed that re-approvals or extensions of existing approvals will not be allowed due to patient non-compliance?   □ Yes □ No

Please check drug being requested below and answer the drug specific questions for the drug selected:

❏ **Daklinza™**
   Please indicate the genotype and treatment regimen being requested:
     ❏ Genotype 1 or 3 without cirrhosis, Daklinza™ + Sovaldi® x 12 weeks
     ❏ Genotype 1 or 3 with decompensated cirrhosis or post-transplant, Daklinza™ + Sovaldi® + RBV x 12 weeks

❏ **Epclusa®**
   Please indicate the genotype and treatment regimen being requested:
     ❏ Genotype 1, 2, 3, 4, 5, or 6 without cirrhosis or with compensated cirrhosis, Epclusa® x 12 weeks
     ❏ Genotype 1, 2, 3, 4, 5, or 6 with decompensated cirrhosis, Epclusa® + RBV x 12 weeks

❏ Harvoni®

Please indicate the genotype and treatment regimen being requested:

- ❏ Genotype 1 treatment-naïve w/out cirrhosis who have pre-treatment HCV RNA less than 6mil IU/ml, Harvoni® x 8 weeks
- ❏ Genotype 1 treatment-naïve w/out cirrhosis who have pre-treatment HCV RNA less than 6mil IU/ml **and** HIV co-infected, Harvoni® x 12 weeks
- ❏ Genotype 1 treatment-naïve w/out cirrhosis or with compensated cirrhosis, Harvoni® x 12 weeks
- ❏ Genotype 1 treatment-experienced w/out cirrhosis, Harvoni® x 12 weeks
- ❏ Genotype 1 treatment-experienced with compensated cirrhosis, Harvoni® x 24 weeks
- ❏ Genotype 1 treatment-naïve or treatment-experienced with decompensated cirrhosis, Harvoni® + RBV x 12 weeks
- ❏ Genotype 1 or 4 treatment-naïve or treatment-experienced liver transplant recipient without cirrhosis or with compensated cirrhosis, Harvoni® + RBV x 12 weeks
- ❏ Genotype 1, aged 12-17 treatment-naive without cirrhosis or with compensated cirrhosis, approve Harvoni® x 12 weeks
- ❏ Genotype 1, aged 12-17 treatment experienced without cirrhosis, approve Harvoni® x 12 weeks
- ❏ Genotype 1, aged 12-17 treatment experienced with compensated cirrhosis, approve Harvoni® + RBV x 24 weeks
- ❏ Genotype 4, 5, or 6 treatment-naïve or treatment-experienced without cirrhosis or with compensated cirrhosis, Harvoni® x 12 weeks
- ❏ Genotype 4, 5, or 6, aged 12-17 without cirrhosis or with compensated cirrhosis, approve Harvoni® x 12 weeks

Please answer drug specific questions below:

- For treatment-naïve patients without cirrhosis, indicate pre-treatment HCV RNA level. _____mil IU/ml
- What is the patient's Glomerular Filtration Rate? _____mL/min/1.73m^2
- If patient is less than 18 years of age, please indicate weight. _____ kg

❏ Mavyret®

Please indicate the genotype and treatment regimen being requested:

- ❏ Genotype 1, 2, 3, 4, 5, or 6 without cirrhosis, approve Mavyret® x 8 weeks
- ❏ Genotype 1, 2, 3, 4, 5, or 6 with compensated cirrhosis, approve Mavyret® x 12 weeks
- ❏ Genotype 1 previously treated with an NS5A inhibitor without prior treatment with an NS3/4A PI without cirrhosis or with compensated cirrhosis, approve Mavyret® x 16 weeks
- ❏ Genotype 1 previously treated with an NS3/4A PI without prior treatment with an NS5A inhibitor without cirrhosis or with compensated cirrhosis, approve Mavyret® x 12 weeks
- ❏ Genotype 1, 2, 4, 5, or 6 previously treated with a PRS with compensated cirrhosis, approve Mavyret® x 12 weeks
- ❏ Genotype 1, 2, 4, 5, or 6 previously treated with a PRS without cirrhosis, approve Mavyret® x 8 weeks
- ❏ Genotype 3 previously treated with a PRS without cirrhosis or with compensated cirrhosis, approve Mavyret® x 16 weeks

❏ Sovaldi®

Please indicate the genotype and treatment regimen being requested:

- ❏ Genotype 1 without cirrhosis, Sovaldi™ + Olysio® with or without RBV x 12 weeks
- ❏ Genotype 1 with cirrhosis, Sovaldi™ + Olysio® with or without RBV x 24 weeks
- ❏ Genotype 1, Sovaldi™ + RBV + peg- interferon alpha x 12 weeks
- ❏ Genotype 1 and peg interferon ineligible, Sovaldi™ + RBV x 24 weeks
- ❏ Genotype 1 or 3 without cirrhosis, Daklinza® + Sovaldi™ x 12 weeks
- ❏ Genotype 1 or 3 with decompensated cirrhosis **or** post-transplant, Daklinza® + Sovaldi™ + RBV x 12 weeks
- ❏ Genotype 2, Sovaldi™ + RBV x 12 weeks
- ❏ Genotype 2, aged 12-17 without cirrhosis or with compensated cirrhosis, approve Sovaldi™ + RBV x 12 weeks
- ❏ Genotype 3, Sovaldi™ + RBV x 24 weeks
- ❏ Genotype 3, Sovaldi™ + RBV + peg-interferon x 12 weeks
- ❏ Genotype 3, aged 12-17 without cirrhosis or with compensated cirrhosis, approve Sovaldi™ + RBV x 24 weeks
- ❏ Genotype 4, Sovaldi™ + RBV + peg-interferon x 12 weeks
- ❏ If hepatocellular carcinoma awaiting liver transplant, Sovaldi™ + RBV x 48 weeks

Please answer drug specific questions below:

- Is the requested medication indicated for monotherapy for this patient? □ Yes □ No
- What is the patient's Glomerular Filtration Rate? _____mL/min/1.73m^2
- Is the patient ineligible for peg-interferon therapy (if yes, indicate reason)?_____ □ Yes □ No
- Is the patient a previous interferon/RBV nonresponder? □ Yes □ No
- Has the patient previously been treated with an HCV protease inhibitor? □ Yes □ No
- If patient is less than 18 years of age, please indicate weight. _____ kg

❏ Technivie™

Please indicate the genotype and treatment regimen being requested:

- ❏ Genotype 4 without cirrhosis, Technivie™ + RBV x 12 weeks

Please answer drug specific questions below:

- Does the patient have cirrhosis or moderate to severe hepatic impairment (Child-Pugh B or C)? □ Yes □ No

❐ **Viekira Pak™ or ❐ Viekira XR™ (indicate which medication)**

Please indicate the genotype and treatment regimen being requested:

❐ Genotype 1a without cirrhosis, Viekira Pak™ or Viekira XR™ + RBV x 12 weeks

❐ Genotype 1a with cirrhosis, Viekira Pak™ or Viekira XR™ + RBV x 24 weeks

❐ Genotype 1b with or without cirrhosis, Viekira Pak™ or Viekira XR™ x 12 weeks

❐ Genotype 1 post-transplant, Viekira Pak™ or Viekira XR™ + RBV x 24 weeks

Please answer drug specific questions below:

- Does the patient have decompensated liver disease or moderate to severe hepatic impairment (Child-Pugh B or C)? □ Yes □ No
- Has the patient received a liver transplant and has normal hepatic function with a Metavir fibrosis score of 2 or lower? □ Yes □ No

❐ **Vosevi®**

Please indicate the genotype and treatment regimen being requested:

❐ Genotype 1, 2, 3, 4, 5, or 6 previously treated with a NS5A inhibitor without cirrhosis or with compensated cirrhosis, approve Vosevi™ x 12 weeks

❐ Genotype 1a or 3 previously treated with sofosbuvir without an NS5A inhibitor without cirrhosis or with compensated cirrhosis, approve Vosevi™ x 12 weeks

❐ **Zepatier®**

Please indicate the genotype and treatment regimen being requested:

❐ Genotype 1a treatment-naïve or peg-interferon/RBV experienced without baseline NS5A polymorphism, Zepatier® x 12 weeks

❐ Genotype 1a treatment-naïve or peg-interferon/RBV experienced with baseline NS5A polymorphism, Zepatier® + RBV x 16 weeks

❐ Genotype 1b treatment-naïve or peg-interferon/RBV experienced, Zepatier® x 12 weeks

❐ Genotype 1a or 1b peg-interferon/RBV/protease inhibitor experienced, Zepatier® + RBV x 12 weeks

❐ Genotype 4 treatment-naïve, Zepatier® x 12 weeks

❐ Genotype 4 peg-interferon/RBV experienced, Zepatier® + RBV x 16 weeks

Please answer drug specific questions below:

- For patient with NS5A polymorphism, is documentation to support polymorphism included? □ Yes □ No

DISPENSING PHARMACY INFORMATION

May Be Completed by Pharmacy

Dispensing pharmacy _____ NPI # _____

Phone # with area code_____ Fax # with area code _____