

Hepatitis C Medication Request Form

Today's date ___/___/___

Submit form to:

Fax: 617.673.0956

Mail: CarePartners of Connecticut
 1 Wellness Way
 Canton, MA 02021-1166
 Attn: Pharmacy Utilization Management Department

Member Information

Last Name:	First Name:
Member ID#:	Member DOB:

Prescriber Information

Prescribing Clinician:	Phone #:
Specialty (required):	Secure Fax #:
NPI #:	DEA/xDEA:
Prescriber Point of Contact Name (POC) (if different than provider):	
POC Phone #:	POC Secure Fax #:

Medication Information

Requested drug(s):	
<input type="checkbox"/> Harvoni <input type="checkbox"/> Viekira Pak <input type="checkbox"/> Viekira XR <input type="checkbox"/> Epclusa <input type="checkbox"/> Sovaldi <input type="checkbox"/> Technivie <input type="checkbox"/> Vosevi <input type="checkbox"/> Mavyret <input type="checkbox"/> Zepatier <input type="checkbox"/> Daklinza <input type="checkbox"/> Ribavirin (generic) <input type="checkbox"/> Ribavirin (Brand) <input type="checkbox"/> Other: _____	
Dose(s): _____ Requested Duration of Treatment: _____ weeks	
Type of therapy: <input type="checkbox"/> Initial <input type="checkbox"/> Continuation - weeks remaining: _____ Anticipated Start Date: _____	

Clinical Information

Diagnosis:		
<input type="checkbox"/> B18.2 Hepatitis C (chronic)	HCV Genotype: <input type="checkbox"/> 1a <input type="checkbox"/> 1b <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	
Stage of Hepatic Fibrosis: <input type="checkbox"/> F0 <input type="checkbox"/> F1 <input type="checkbox"/> F2 <input type="checkbox"/> F3 <input type="checkbox"/> F4		
For members with early stage liver disease (Metavir Score F0-F2), please describe the medical necessity for requesting treatment at this time:		
_____ _____ _____		
Is the medication prescribed by a gastroenterologist, infectious disease specialist, or hepatologist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was the staging of hepatic fibrosis performed by a specialist through one of the following?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<p>Please check all that apply and attach documentation including medical records and results of diagnostic tests:</p> <p><input type="checkbox"/> Liver biopsy confirming METAVIR score <input type="checkbox"/> Transient elastography (Fibroscan) score</p> <p><input type="checkbox"/> Fibrotest (FibroSURE) score of greater <input type="checkbox"/> Radiological imaging</p> <p><input type="checkbox"/> APRI score</p> <p><input type="checkbox"/> Physical findings or clinical evidence consistent with cirrhosis as attested by the prescriber</p>		
Is there documented evidence of chronic liver disease, or in the absence of chronic liver disease, serologic evidence of persistent infection for at least six months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the patient have HIV coinfection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has Hepatitis B screening been performed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>If patient has active Hepatitis B infection, has the risk of Hepatitis B reactivation been assessed?</p> <p>Caution: FDA has warned about the risk of Hepatitis B reactivating in some patient treated with direct acting antiviral agents for Hepatitis C. AASLD recommends treating Hepatitis B concurrently or prior to Hepatitis C treatment.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Does the patient have severe renal impairment or end-stage renal disease, or require dialysis?</p> <p>Confirm the patient's GFR range: <input type="checkbox"/> 0 – 14 <input type="checkbox"/> 15 – 29 <input type="checkbox"/> > / = 30</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Has the patient been previously treated for Hepatitis C and failed treatment?</p> <p>If yes, when? _____ What treatment(s)? _____</p> <p>Response to treatment: <input type="checkbox"/> Relapsed <input type="checkbox"/> Partial response <input type="checkbox"/> Did not complete</p> <p><input type="checkbox"/> Null response (< 2 log reduction in HCV RNA at week 12)</p> <p>Adverse reaction? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>HCV RNA levels:</p> <p>Baseline within 6 months of beginning treatment (required): _____ IU/mL Date of lab work: _____</p> <p>Post-therapy:</p> <p>12 weeks after completion of treatment: _____ IU/mL Date of lab work: _____</p>		

<p>Has there been confirmation that the patient does not have a genotype 1a with NS3 Q80K polymorphism? (Olysio only)</p>	<input type="checkbox"/> Unknown	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Has there been confirmation that the patient does not have a genotype 1a with a baseline NS5A polymorphism? (Zepatier only)</p>	<input type="checkbox"/> Unknown	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>Will hepatic laboratory testing be performed prior to therapy, at treatment week 8, and as clinically indicated?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<p>Does the patient have a diagnosis of hepatocellular carcinoma that meets Milan criteria?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<p>If the patient requires a dosage form other than ribavirin 200mg capsules or tablets, document clinical reason and provide dosage form.</p> <p>Dosage form: _____</p> <p>Clinical reason: _____</p>			
<p>Are any of the following statements true?</p> <p><input type="checkbox"/> Patient is pregnant or is planning to become pregnant within 6 months after completion of treatment</p>			

<input type="checkbox"/> Patient is male with a female partner who is pregnant or is planning to become pregnant within 6 months after completion of treatment <input type="checkbox"/> None of the above		
Is the member currently awaiting a liver transplant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the member have cirrhosis? <i>If yes, please choose one:</i>		
<input type="checkbox"/> Compensated (Child-Turcotte-Pugh Class A; no major complication of cirrhosis)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Decompensated (Child-Turcotte-Pugh Class B or C)		
Is the patient being managed in a liver transplant center?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the member actively participating in illicit substance abuse or alcohol abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there documented attestation that the member has been assessed for potential nonadherence?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the member is receiving substance or alcohol abuse counseling services or seeing an addiction specialist as an adjunct to HCV treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has a treatment plan been developed and discussed with the patient?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did the prescriber identify any potential issues with adherence? <i>If yes, please describe:</i> _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have drug interactions been reviewed and evaluated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Does this member reside in long-term care? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the member enrolled in Hospice? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, disenrollment date: _____
Is the drug related to the terminal illness or related conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No
Provide an explanation of why the drug being prescribed is unrelated to the terminal illness/related conditions: _____ _____
Is this a request for a formulary tier exception (the member's drug plan charges a higher copayment for the drug prescribed than it charges for another drug that treats the condition, and I want to pay the lower copayment – excludes nonformulary drugs and drugs on the specialty tier)? <input type="checkbox"/> Yes* <input type="checkbox"/> No
*If yes, a supporting statement from the prescribing physician is required. Please specify the request: (1) formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome

By checking the following box, I certify that applying the standard review time frame may seriously jeopardize my patient's life, health, or ability to attain, maintain, or regain maximum function. Request for expedited review

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber signature (STAMP NOT ACCEPTED)

Date