Alabama Medicaid Pharmacy
Hepatitis C Antiviral Agents PA Request Form

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail
KEPRO

P.O. Box 3570
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 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/mm^3
- 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
- Is the patient a recipient of an organ from a hepatitis C infected donor? □ Yes □ No

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

❒ Epclusa® or ❒ Sofosbuvir - velpatasvir

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® or ❒ Ledipasvir - sofosbuvir

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 or African-American, 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 3-17 treatment-naive without cirrhosis or with compensated cirrhosis, approve Harvoni® x 12 weeks
- ❒ Genotype 1, aged 3-17 treatment experienced without cirrhosis, approve Harvoni® x 12 weeks
- ❒ Genotype 1, aged 3-17 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 3-17 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 HCVRNA level._____mil IU/ml
- 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 8 weeks
❒ Genotype 1, 2, 3, 4, 5, or 6 for ages > 12 years and weighing at least 45 kg who are liver or kidney transplant recipients, 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, Sovaldi™ + RBV + peg- interferon alpha x 12 weeks
❒ Genotype 1 and peg interferon ineligible, Sovaldi™ + RBV x 24 weeks
❒ Genotype 2, Sovaldi™ + RBV x 12 weeks
❒ Genotype 2, aged 3-17 without cirrhosis or with compensated cirrhosis, approve Sovaldi™ + RBV x 12 weeks
❒ Genotype 3, Sovaldi™ + RBV x 24 weeks
❒ Genotype 3, aged 3-17 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

❒ 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_____