

# Alabama Medicaid Pharmacy Hepatitis C Antiviral Agents PA Request Form

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

Fax or Mail  
HEALTH INFORMATION

P.O. Box 3210  
Auburn, AL 36832-3210

## 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 \_\_\_\_\_
  - Child-Turcotte-Pugh (CTP) classification \_\_\_\_\_
  - Acoustic Radiation Force Impulse Image (ARFI) \_\_\_\_\_ m/sec
  - 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
  - AST to Platelet Ratio Index (APRI) \_\_\_\_\_
  - Fibroscan value \_\_\_\_\_ kilopascals
  - Fibrosis-4 (FIB-4) Score \_\_\_\_\_
- \*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/mm<sup>3</sup>
- 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:

#### 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, Harvoni® x 12 weeks
- Genotype 1 treatment-experienced w/out cirrhosis, Harvoni® x 12 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, Harvoni® + RBV x 12 weeks
- Genotype 4, 5, or 6 treatment-naïve or treatment-experienced without cirrhosis, 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<sup>2</sup>

**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, Epclusa® x 12 weeks
- Genotype 1, 2, 3, 4, 5, or 6 with decompensated cirrhosis, Epclusa® + RBV x 12 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 3, Sovaldi™ + RBV x 24 weeks
- Genotype 3, Sovaldi™ + RBV + peg-interferon x 12 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<sup>2</sup>
- 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

**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™**

**Please indicate the genotype and treatment regimen being requested:**

- Genotype 1a without cirrhosis, Viekira Pak™ + RBV x 12 weeks
- Genotype 1a with cirrhosis, Viekira Pak™ + RBV x 24 weeks
- Genotype 1b with or without cirrhosis, Viekira Pak™ x 12 weeks
- Genotype 1 post-transplant, Viekira Pak™ + 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

**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 \_\_\_\_\_