MID-WEST SPECIALTY PHARMACY

PHONE: (888)544-1111 FAX:(424)777-0888

Hepatitis C Prior Authorization Form

PATIENT INFORMATION

Please fax copy of patient's insurance card including both sides

Patient Name _____

DOB _____ Last Four of SS# _____ Gender _____

Weight _____ Height _____ Phone _____

Address _____

City, State, ZIP _____

Language Preference: ☐ English ☐ Spanish ☐ Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____

DEA _____ NPI _____

Group/Hospital _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____

Contact Person _____ Phone _____

INSURANCE INFORMATION *(Must fax a copy of patient's insurance card including both sides)*

Prior Authorization Reference number _____

MEDICAL INFORMATION *(Section must be completed to process prescription)* *(Attach separate sheet if needed)*

☐ B18.2 Chronic Hepatitis C ☐ K72.90 Hepatic failure, unspecified without coma ☐ C22.0 Liver Cell Carcinoma

☐ Other Diagnosis: ICD-10 Code _____ Description _____

Genotype _____ Viral Load _____ IU/ml Viral Load Date _____ HIV Coinfected: ☐ Yes ☐ No HBV Coinfected: ☐ Yes ☐ No

Previous therapy history: Naïve _____ Relapsed _____ Partial Responder _____ Null _____

Date(s) of previous therapy and meds _____

Cirrhosis: ☐ Yes ☐ No ☐ Compensated OR ☐ Decompensated Fibrosis Score _____

Liver Transplant: ☐ Yes ☐ No Waiting for Liver Transplant: ☐ Yes ☐ No

Please include hard copies of: genotype, viral load, liver biopsy scans, CBC, CMP, HIV, PT/INR, H&P, NS5A resistance testing and pertinent office visit notes.

PRESCRIPTION INFORMATION

☐ **DAKLINZA®** (daclatasvir) ☐ 30mg ☐ 60mg Disp. 28 Sig: One tablet daily with or without food. Refill: x _____ Total duration of therapy _____ Weeks

☐ **EPCLUSA** (sofosbuvir 400mg/velpatasvir 100mg) disp. 28 Sig: 1 tablet daily Refill: x _____ Total duration of therapy _____ Weeks

☐ **HARVONI®** (ledipasvir 90mg/sofosbuvir 400mg) disp. 28 Sig: 1 tablet daily Refill: x _____ Total duration of therapy _____ Weeks

☐ **MAVYRET™** (glecaprevir 100mg/pibrentasvir 40mg) disp 84 Refill: x _____ Total duration of therapy _____ Weeks

Sig: Take 3 tablets (contents of one daily dose card) by mouth once daily with food.

RIBAVIRIN 200mg:

Directions _____

Quantity _____

Refill: x _____ Total duration of therapy _____ Weeks

☐ < 75kg = 1000mg/day

☐ ≥ 75kg = 1200mg/day

RIBAPAK (28 day supply):

☐ 1200mg daily/600mg QAM—600mg QPM

☐ 1000mg daily/600mg QAM—400mg QPM

☐ 800mg daily/400mg QAM—400mg QPM

☐ 600mg daily/200mg QAM—400mg QPM

Refill: x _____ Total duration of therapy _____ Weeks

MODERIBA (28 day supply):

☐ 1200mg daily/600mg QAM—600mg QPM

☐ 1000mg daily/600mg QAM—400mg QPM

☐ 800mg daily/400mg QAM—400mg QPM

☐ 600mg daily/200mg QAM—400mg QPM

Refill: x _____ Total duration of therapy _____ Weeks

☐ **SOVALDI™** (sofosbuvir) 400mg disp. 28 Sig: 400mg daily Refill: x _____ Total duration of therapy _____ Weeks

☐ **TECHNIVIE™** Disp. 28 day supply Sig: Take 2 tablets once daily (in am) with food. Refill: x _____ Total duration of therapy _____ Weeks

☐ **VIEKIRA XR** disp. 84 tabs (28 day supply) Sig: Take 3 tablets by mouth once daily. Refill: x _____ duration of therapy _____ Weeks

☐ **VIEKIRA PAK** disp. 28 day supply. Refill: x _____ duration of therapy _____ Weeks

Sig: Take 2 ombitasvir, paritaprevir, ritonavir 12.5mg/75mg/50mg tablets once daily (in am) and 1 dasabuvir 250mg tablet twice daily (am & pm) with a meal.

☐ **VOSEVI** Disp. 28 day supply Sig: Take once daily with food Refill: x _____ Total duration of therapy _____ Weeks

☐ **ZEPATIER** (elbasvir 50mg/grazoprevir 100mg) disp. 28 Refill: x _____ duration of therapy _____ Weeks

Sig: Take 1 tablet daily with or without food. ☐ NS5A resistance testing included

Supportive Therapy: ☐ **PROMACTA® PO QD** ☐ 12.5mg tablets ☐ 25mg tablets ☐ 50mg tablets ☐ 75mg tablets ☐ 100mg tablets

Quantity _____ Refill: x _____ Total duration of therapy _____ Weeks ***Titrate based on platelet count not to exceed 100mg PO QD**

Statement of medical necessity: I certify the prescribed therapy is medically necessary. I will be supervising the patient treatment accordingly and all information is accurate to the best of my knowledge. I authorized Mid-West Pharmacy as my designated agent on behalf of my patient to (1) Provide any information on this form to the insurer of the above name patient and to (2) forward the above prescription by fax or other mode of delivery to the pharmacy chosen by the above name patient.

Prescriber Signature _____ **Date** _____