

Viekira Pak™ & XR™ (Ombitasvir/Paritaprevir/Ritonavir/Dasabuvir) Initiation Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____
 Pharmacy NPI: _____ Pharmacy Phone: _____ Pharmacy Fax: _____
 Pharmacy Name: _____ Pharmacist Name: _____
 Prescriber NPI: _____ Prescriber Name: _____ Specialty: _____
 Prescriber Phone: _____ Prescriber Fax: _____ Drug Name: _____
 NDC: _____ Start Date: _____

Clinical Information

1. HCV Genotype (including subtype): _____ Date Determined: _____
2. METAVIR Equivalent Fibrosis Stage: _____ Testing Type: _____
Date Fibrosis Stage Determined: _____
3. Pre-Treatment Viral Load: _____ Date Determined: _____
4. Does member have decompensated hepatic disease or moderate-to-severe hepatic impairment (Child-Pugh B or C)? Yes ___ No ___
5. Is the member currently on hospice or does the member have a limited life expectancy (less than 12 months) that cannot be remediated by treating HCV? Yes ___ No ___
6. Has the member been evaluated by a gastroenterologist, infectious disease specialist, or a transplant Specialist for hepatitis C therapy within the past 3 months? Yes ___ No ___
7. If yes, please include name of specialist recommending hepatitis C treatment: _____
8. Has the member been previously treated for hepatitis C? Yes ___ No ___
9. If yes, please indicate previous treatment regimen and reason for failure (relapser, null-responder, partial responder): _____
10. Please indicate requested regimen below:
 - Genotype 1a, without cirrhosis: Viekira Pak™ or XR™ with weight-based ribavirin x 84 days (12 weeks)
 - Genotype 1a with cirrhosis: Viekira Pak™ or XR™ with weight-based ribavirin x 168 days (24 weeks)
 - Genotype 1b without cirrhosis or with compensated cirrhosis: Viekira Pak™ or XR™ x 84 days (12 weeks)
 - Other: _____
11. Has the member signed the intent to treat contract**? Yes ___ No ___ ***Required for processing of request*
12. Has the member been counseled on the harms of illicit IV drug use and alcohol use and agreed to not use illicit IV drugs or alcohol while on or after they finish hepatitis C treatment? Yes ___ No ___
13. Has the member initiated immunization with the hepatitis A and B vaccines? Yes ___ No ___
14. For women of childbearing potential (and male patients with female partners of childbearing potential):
 - Patient is not pregnant (or a male with a pregnant female partner) and not planning to become pregnant during treatment
 - Agreement that partners will use two forms of effective non-hormonal contraception during treatment and for at least 6 months after completing treatment
Please list non-hormonal birth control options discussed with member _____
 - Verification that monthly pregnancy tests will be performed throughout treatment
15. Is the member taking any of the following medications: alfuzosin, carbamazepine, phenytoin, phenobarbital, gemfibrozil, rifampin, ergotamine, dihydroergotamine, ergonovine, methylegonovine, ethinyl estradiol, St. John's wort, lovastatin, simvastatin, pimozide, efavirenz, sildenafil, triazolam, midazolam? Yes ___ No ___
16. Have all other clinically significant issues been addressed prior to starting therapy? Yes ___ No ___
17. Will the member's ALT levels be monitored during the first four weeks of starting treatment and as clinically indicated thereafter? Yes ___ No ___
 - I recommend this patient be followed by an OHCA Care Management Nurse.

Members must be adherent for continued approval. Treatment gaps of therapy longer than 3 days will result in denial of payment for subsequent requests for continued therapy. Refills must be prior authorized.

Prescriber Signature: _____ Date: _____

Has the member been counseled on appropriate use of Viekira Pak™ therapy? Yes ___ No ___

Pharmacist Signature: _____ Date: _____

Please do not send in chart notes. Specific information/documentation will be requested if necessary. Failure to complete this form in full will result in processing delays. By signature, the prescriber or pharmacist confirms the above information is accurate.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

CONFIDENTIALITY NOTICE

This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.