SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Epclusa® (Sofosbuvir/Velpatasvir) 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 if applicable): _____ Date Determined: _____
2. METAVIR Equivalent Fibrosis Stage:_____ Testing Type:_____
   Date Fibrosis Stage Determined:_____
3. If member is cirrhotic & genotype-3, is member positive for Y93H resistance-associated variant? Yes ____ No____
   **Ribavirin must be added to treatment regimen if member is cirrhotic, genotype-3, and Y93H positive or unwilling to test.*
4. Pre-Treatment Viral Load:_____ Date Determined: _____
5. Does member have decompensated hepatic disease (CTP class B or C)? Yes___ No___
6. 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____
7. Does the member have severe renal impairment (estimated eGFR <30mL/min/m^2 ? Yes____ No___
8. Has the member been evaluated by a gastroenterologist, infectious disease specialist, or a transplant specialist within the past 3 months? Yes___ No___
9. If yes, please include name of specialist recommending hepatitis C treatment: _____
10. Has the member been previously treated for hepatitis C? Yes___ No___
11. If yes, please indicate previous treatment regimen and reason for failure (relapser, null-responder, partial responder): _____
12. Please indicate requested regimen below:
    - ❑ Epclusa® 400mg/100mg daily x 84 days (12 weeks)
    - ❑ Epclusa® 400mg/100mg daily with weight-based ribavirin x 84 days (12 weeks)
    - ❑ Other:_____
13. Has the member signed the intent to treat contract**? Yes___ No___ ***Required for processing of request*
14. 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____
15. Has the member initiated immunization with the hepatitis A and B vaccines? Yes___ No___
16. 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 six months after therapy completion for those on ribavirin). Please list non-hormonal birth control options discussed with member_____
17. Is the member taking any of the following medications: H2-receptor antagonists at doses greater than 40mg famotidine equivalent, amiodarone, omeprazole or other proton pump inhibitors, topotecan, rifampin, rifabutin, rifapentine, carbamazepine, eslicarbazepine, phenytoin, phenobarbital, oxcarbazepine, efavirenz, tenofovir disoproxil fumarate, tipranavir/ritonavir and St. John's wort? Yes___ No___
18. If member is using antacids have they agreed to separate antacid and Epclusa® administration by 4 hours? Yes___ No___ NA___
19. Have all other clinically significant issues been addressed prior to starting therapy? 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 Epclusa® therapy? Yes___ No___
Pharmacist Signature: _____ **Date:** _____

Please do not send in chart notes. 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