FIDELIS CARE MEDICATION REQUEST
FORM FOR HEPATITIS C (HCV) AGENTS (4/10/2017)
Copies of this form and additional information available at
http://www.fideliscare.org/pharmacy

Complete this form and fax to **1-877-533-2405**. Fidelis Care will notify you within 72 hours as to what determination has been made. If you have any questions, please dial 1-888-FIDELIS (1-888-343-3547) and follow the appropriate prompts. **To avoid unnecessary delays, please ensure that you complete the form in its entirety and print neatly to help expedite the drug coverage review process.** Provision of the information requested on this form ***does not guarantee*** coverage. This list is ***not*** all-inclusive – please submit any patient-specific information relevant to the request, with supporting documentation.

Member Name_____ **ID#**_____

DOB_____ **Age**_____ **Height**_____ **Weight**_____ **Sex**_____

Prescriber name_____ **NPI**_____ **Contact Person** _____

Address_____**City**_____ **County/State**_____ **Zip** _____

Phone number_____ **Ext.**_____ **Fax**_____

The following information is requested as per criteria developed by the New York State Department of Health Drug Utilization Review Board (NYSDOH DURB).

Specialty ☐ Hepatologist ☐ Gastroenterology ☐ Transplant physician ☐ Infectious Disease ☐ Other_____

HCV Clinical Experience ☐ Treatment for HCV in ≥ 10 patients within last 12 months; and Obtained ≥ 10 HCV-related CME credits in the last 12 months

OR

☐ Management & treatment of HCV infection in partnership (i.e. consultation, preceptorship, or via telemedicine) with an experienced HCV provider who meets the above criteria (include name of collaborating provider below)

Name _____ **NPI** _____ **Phone #** _____

IMPORTANT: HARD COPY CLINICAL/CHART NOTES and/or HARD COPY LABORATORY RESULTS *MUST BE ATTACHED* IN SUPPORT OF THE FOLLOWING CRITERIA UNLESS OTHERWISE NOTED:

1. **Hepatitis C Genotype**
2. **NS5A drug resistance testing (REQUIRED for Zepatier requests, genotype 1a)**
3. **HCV RNA level** (within the last 12 months)
4. **Prior treatment status:** ☐ Treatment-Naïve ☐ Relapser or Non-responder with prior use of the following meds: _____

   _____
5. **Comorbid conditions:** ☐ Compensated Cirrhosis ☐ Decompensated Cirrhosis ☐ Severe renal impairment ☐ HIV
6. **Is the patient taking P-gp inducers (such as rifampin or St. John's Wort), anticonvulsants, or other drugs (prescribed or over-the-counter) that may affect Hep C treatment? If so, which products?** (chart notes not required):_____

   _____
7. **Patient demonstration of readiness, willingness, and ability to adhere to the requested drug regimen.** Important: Note that a lapse in therapy of ≥ 14 days is grounds for Fidelis Care to discontinue treatment.
8. **Patient verbal or written commitment to planned course of treatment, including anticipated blood tests and visits during and after treatment.** (chart notes not required)
9. **Has the patient acknowledged that lost, stolen, destroyed, or inappropriately used supplies are not subject to replacement by Fidelis Care**? ☐ Yes ☐ No

10. Requested Medications:

☐ Zepatier once daily ☐ Epclusa once daily ☐ Harvoni once daily

☐ Daklinza 30mg once daily ☐ Daklinza 60mg once daily ☐ Daklinza 90mg once daily

☐ Sovaldi 400mg once daily ☐ Other: _____

☐ Ribavirin* 200mg; dosing schedule: _____

** Please note **generic ribavirin 200mg is the preferred product** (Branded formulations of ribavirin are non-formulary)*

11. Expected duration of therapy: ☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ 24 weeks ☐ Other (attached rationale required): _____

12. *IMPORTANT – FOLLOW-UP LABS:* Hep C regimens are approved based on therapy appropriateness on initial review for a 4 to 8 week duration; the remaining duration is approved pending receipt of follow-up viral load laboratory results. A follow-up viral load drawn within the first 2-4 weeks of treatment for 8, 12, and 16-week total durations must be sent to Fidelis Care. For durations exceeding 16 weeks, a second follow-up viral load, drawn between treatment weeks 10-14, must be sent to Fidelis Care. A post treatment lab is also requested 12 weeks after the end of pharmacological treatment to evaluate sustained virological response (SVR). Please carefully read the chart below to find the due date(s) required for your patient.

	Total Treatment Duration	Initial Approval Duration	1st Follow-up Viral Load Drawn	Follow-up Viral Load sent to FCNY	Continuation Approval Duration	2nd Follow-up Viral Load Drawn	Follow-up Viral Load sent to FCNY	Continuation Approval	Post treatment lab (SVR)
☐	8 weeks (Harvoni only)	4 weeks	Week 2	Before Week 3	Remaining 4 weeks	---	---	---	12 weeks after treatment end
☐	12 weeks	8 weeks	Week 2 to Week 4	Before Week 6	Remaining 4 weeks	---	---	---	12 weeks after treatment end
☐	16 weeks	8 weeks	Week 2 to Week 4	Before Week 6	Remaining 8 weeks	---	---	---	12 weeks after treatment end
☐	24 weeks	8 weeks	Week 2 to Week 4	Before Week 6	8 weeks	Week 10 to Week 14	Before Week 15	Remaining 8 weeks	12 weeks after treatment end

- If approved, I agree to require my patient to come in for follow-up exams (as appropriate; see above table) to draw labs for evaluation of adherence and therapy effectiveness in order to continue therapy. I will also have the results forwarded to Fidelis Care for continued coverage of the remaining regimen supply. I also agree to require my patient to come in 12 weeks after treatment end to draw labs for evaluation of therapy success rate and forward to Fidelis Care.
- If approved, I am aware that Fidelis Care will not replace medications that are lost, stolen, destroyed, or inappropriately used by the patient and that the patient is responsible for the safekeeping of his/her medication supply.
- If approved, I am aware that non-adherence to the medication compromises the effectiveness of the treatment and that a lapse in use of 14 days or more is grounds for discontinuation of the treatment regimen by the plan.
- I attest that this information is accurate and true, and that the supporting documentation is available for review upon request of said plan, the NYSDOH or CMS. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a Medicaid MC claim may be subject to civil penalties and treble damages under both federal and NYS False Claims Acts.

Prescriber's Signature _____ **Date** _____

Reminder Before Submitting (*see points above for details and hard copy requirements*) – Prior Authorization Checklist

☐ Completed form (provider information and questions #1-#12) ☐ Chart notes as needed

☐ Laboratory results: Genotype, HCV RNA within past 12 months, NS5A resistance test report for Zepatier requests (genotype 1a only)