carolina complete health

Pharmacy Prior Approval Request for Zepatier: Initial PA Form

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. ____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☒ 8 Weeks (Only 8 weeks can be approved with this form. Must use continuation form to request additional therapy)

Clinical Information

☐ **12 weeks =** Genotype 1a and treatment naïve or PegIFN/RBV-experienced without baseline NS5A polymorphisms; genotype 1b and treatment naïve or PegIFN/RBV-experienced; Genotype 1a or 1b and PegIFN/RBV/PI-experienced; or Genotype 4 and treatment-naïve.

☐ **16 weeks** = Genotype 1a and treatment-naïve or PegIFN/RBV-experienced with baseline NS5A polymorphisms; or Genotype 4 and PegIFN/RBV-experienced.

1. Is the beneficiary 18 years of age or older with a diagnosis of chronic hepatitis C (CHC) with confirmed genotype 1 or genotype 4?
   ☐ **Yes** ☐ **No Genotype is: _____ Fibrosis stage is: _____**
2. Are medical records documenting the diagnosis of chronic hepatitis C with genotype and subtype being submitted with this request? ☐ **Yes** ☐ **No** ****Lab test results MUST be attached to the PA to be approved.****
3. Which of the following are included with the submitted medical records to document the staging of liver disease?
   ☐ Metavir scores ☐ FibroSure score ☐ IASL scores ☐ Batts-Ludwig scores
   ☐ Fibroscan score ☐ Ishak scores ☐ APRI scores ☐ Radiological imaging consistent with cirrhosis
   ☐ Physical findings or clinical evidence consistent with cirrhosis as attested by the prescribing physician
4. Is the beneficiary being prescribed Zepatier in conjunction with ribavirin if he/she has a genotype 1a baseline NS5A polymorphisms, genotype 1a or 1b who are treatment experienced with Peginterferon alfa + ribavirin + HCV NS3/4A protease inhibitor or genotype 4 who are treatment experienced with Peginterferon alfa + ribavirin? ☐ **Yes** ☐ **No**
5. Does the beneficiary have a documented quantitative HCV RNA at baseline that was tested within the past 6 months (medical documentation required)? ☐ **Yes** ☐ **No HCN RNA (IU/ml): _____ and/or log10 value: _____**
7. As the provider, are you reasonably certain that treatment will improve the beneficiary's overall health status?
   ☐ **Yes** ☐ **No**
8. Does the beneficiary have FDA labeled contraindications to Zepatier? ☐ **Yes** ☐ **No**
9. Does the Beneficiary have moderate to severe hepatic impairment (child-pugh B or C) or any history of prior hepatic decompensation? ☐ **Yes** ☐ **No**
10. Is Zepatier being co administered with organic anion transporting polypeptides 1B1/3 (OATP1B1/3) inhibitors, strong inducers of cytochrome P450 3A (CYP3A), or efavirenz. ☐**Yes** ☐**No**

Signature of Prescriber:_____Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (866)-399-0929 Pharmacy PA Call Center: (833) 585-4309