AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Viekira

Beneficiary Information

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

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 28 Days: __112__
11. Length of Therapy: ___12 weeks ___24 weeks

Clinical Information

Total length of therapy being requested (Check ONE):
___ **12 weeks** = Genotype 1a, without cirrhosis, or genotype 1b, with cirrhosis.
___ **24 weeks** = Genotype 1a, with compensated cirrhosis.

1. Is the beneficiary 18 years of age or older with a diagnosis of chronic hepatitis C (CHC) infection with confirmed genotype 1 b without cirrhosis or with compensated cirrhosis or confirmed genotype 1a without cirrhosis or with compensated cirrhosis in combination with ribavirin? Yes___ No___ **Genotype is:** _____
2. For all treatment courses except genotype 1b (without cirrhosis), will treatment include the use of ribavirin? Yes___ No___
3. As the provider, are you reasonably certain that treatment will improve the beneficiary's overall health status? Yes___ No___
4. Has the provider assessed for laboratory and clinical evidence of hepatic decompensation? Yes___ No___
5. Does the beneficiary have cirrhosis? Yes___ No___ If the answer is yes, please answer the following:
   5a. Is the beneficiary being monitored for clinical signs and symptoms of hepatic decompensation (such as ascites, hepatic encephalopathy, variceal hemorrhage)? Yes___ No___
   5b. Has the beneficiary received hepatic laboratory testing including direct bilirubin levels at baseline and during the first four weeks of starting treatment and as clinically indicated? Yes___ No___
6. Is Viekira Pak being used in combination with other protease inhibitors used to treat CHC (i.e. boceprevir, simeprevir, or telaprevir) or in combination with another nucleotide NS5B polymerase inhibitor such as Sovaldi® (sofosbuvir)? Yes___ No___
7. Is the beneficiary using Viekira Pak in combination with another NS5A inhibitor? Yes___ No___
8. Is the beneficiary requesting the regimen for re-treatment and either failed to achieve a SVR (defined as a lower limit HCV RNA of 25 IU/mL) or relapsed after achieving a SVR during a prior successfully completed treatment regimen consisting of Sofosbuvir? Yes___ No___
9. Is the beneficiary requesting the regimen for re-treatment and either failed to achieve a SVR (defined as a lower limit HCV RNA of 25 IU/mL) or relapsed after achieving a SVR during a prior successfully completed treatment regimen consisting of Ledipasvir? Yes___ No___
10. Does the beneficiary have decompensated liver disease as defined by Child-Pugh classification score of Child Class B or C (VIEKIRA PAK™ is contraindicated in beneficiaries with moderate to severe hepatic impairment (Child-Pugh B and C))? Yes___ No___
11. Has the beneficiary attempted a previous course of therapy with Viekira Pak? Yes___ No___
12. Does the beneficiary have any FDA-labeled contraindications to Viekira Pak? Yes___ No___
13. Has the beneficiary tried and failed 2 preferred medications in this class or does the beneficiary have a reason or contraindication to the preferred medications in the class? Yes___ No___

Please list tried/failed medications and/or any contraindications to the preferred medications: _____
_____

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: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406