Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

# Horizon NJ Health

## *Hepatitis C Treatment – Medical Necessity Request*

1. Which drugs are being requested (please include the requested dose, directions and length of therapy for each)?

| | | | | | |
|---|---|---|---|---|---|
| □ Pegasys: ________________ | | □ 12 weeks | □24 weeks | □ 16 weeks | □ Other: ____________ |
| □ PegIntron: _______________ | | □ 12 weeks | □24 weeks | □ 16 weeks | □ Other: ____________ |
| □ Ribavirin: ________________ | | □ 12 weeks | □24 weeks | □ 16 weeks | □ Other: ____________ |
| □ Sovaldi 400mg once daily | | □ 12 weeks | □24 weeks | □ 16 weeks | □ Other: ____________ |
| □ Harvoni 90-400mg once daily | □ 8 weeks | □ 12 weeks | □24 weeks | □ 16 weeks | □ Other: ____________ |
| □ Viekira Pak | | □ 12 weeks | □24 weeks | □ 16 weeks | □ Other: ____________ |
| □ Daklinza 60mg once daily | | □ 12 weeks | □24 weeks | □ 16 weeks | □ Other: ____________ |
| □ Zepatier 50-100mg once daily | | □ 12 weeks | □24 weeks | □ 16 weeks | □ Other: ____________ |
| □ Epclusa 400-100mg once daily | | □ 12 weeks | □24 weeks | □ 16 weeks | □ Other: ____________ |
| □ Mavyret 300-120mg daily | □ 8 weeks | □ 12 weeks | □24 weeks | □ 16 weeks | □ Other: ____________ |
| □ Vosevi | | □ 12 weeks | □24 weeks | □ 16 weeks | □ Other: ____________ |
| □ Other: ___________________ | | □ 12 weeks | □24 weeks | □ 16 weeks | □ Other: ____________ |

2. What is the member's weight? _____lbs ____kg
3. What is the member's height?_____feet _____ inches

4. What is the diagnosis? □ **Hepatitis C** - Please indicate genotype: □1a □ 1b □ 2 □ 3 □ 4 □ 5 □ 6 □ **Other**: _______________
   ***Please submit lab documentation of genotype.***

5. What date did the member start or is planning to start therapy? _____________

6. Has the member previously been treated for Hepatitis C? **Yes or No**
   - If yes, what drugs was the member treated with and what dates were they filled (if dates unavailable, provide length of therapy)?
     _________________________________________________________________________________________
   - Please indicate member's treatment response:
     □ Null-responder □ Relapser □ Partial Responder □ Other (please specify):___________________
   - Please provide the HCV RNA levels in IU/mL from previous therapy: ___________________________
   - Is the member currently in the middle of therapy? **Yes or No** **-** If yes, how many weeks has the member received? ___________

7. Does member have cirrhosis? □ No cirrhosis
   □ Compensated cirrhosis
   □ Decompensated cirrhosis
   **-** What is the Child Turcotte Pugh (CTP) class: □ A (5-6 points) □ B (7-9 points) □ C (10-15 points)

8. For members with cirrhosis, please provide the following scores regarding the member's level of fibrosis. ****Please fax over biopsy/lab documentation***.
   - Metavir fibrosis score: □ 0 (No fibrosis) □ 1 □ 2 □ 3 □ 4
   - Fibroscan score: _____________
   - FibroSURE score: ___________
   - APRI score: ________________
   - FIB-4 (Fibrosis-4 index): ______________

9. Has the member been tested for the Hepatitis B virus? **Yes or No** ****Please fax over lab documentation of Hepatitis B testing that assesses Hepatitis B surface antigen (HBsAg), Hepatitis B surface antibody (anti-HBs), and antibodies to Hepatitis B core antigen (anti-HBc).***

10. Has the member had an organ transplant? **Yes or No**
    **If yes, date of transplant____________ Which organ? _____________________*

**Physician office's signature*_________________________________ Print Name_________________________________**
***Form must be completed and signed by physician or licensed representative from the physician's office**

11. Does the member have hepatocellular carcinoma?
    □**Yes – Please answer the following:**
    - Is the member awaiting liver transplantation? **Yes or No**
    - What date is the liver transplant scheduled for: __________

    □ **No**

12. Which specialist is prescribing the medication(s): □ Gastroenterology, □ Infectious Disease, □ Hepatology, □ Liver Transplant,
    □ Other: __________

13. What is the member's estimated glomerular filtration rate (eGFR) ____________ (ml/min)?
    ***Please submit documentation from within the past 30 days***

14. Please provide the current HCV RNA level taken within the past 90 days and date taken.
    - Level: _____________IU/ml Date Taken: ______________ ***Please fax over lab report confirming this level.**

15. Is the member eligible to receive ribavirin?
    □ **Yes**
    □ **No** – Please provide the specific reason why the member cannot take ribavirin. Please submit a copy of lab work from within the past 30 days if applicable for the reason provided.
    ____________________________________________________________________________________________________
    ____________________________________________________________________________________________________
    ____________________________________________________________________________________________________

16. **Please submit a copy of all resistance testing results** (e.g., NS5A resistance-associated substitutions (RAS), Y93H, Q80 polymorphism, etc.)

17. Please fax over any additional labs or clinical information pertaining to the member's diagnosis.

***Continued on p. 3***

**Physician office's signature*_________________________________ Print Name________________________________**
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

24. **For each drug being requested, please indicate if member has any of the listed conditions or is taking any of the listed drugs.**

**Zepatier**

□ Moderate/severe hepatic impairment (CTP Class B/C)
□ Atazanavir (e,g., Evotaz, Reyataz)
□ Atorvastatin >20mg/day
□ Bosentan
□ Carbamazepine, phenytoin
□ Cobicistat (Stribild, Evotaz, Prexcobix, Genvoya, Tybost)
□ Cyclosporine
□ Darunavir (e.g., Prezcobix, Prezista)
□ Efavirenz (e.g., Atripla, Sustiva, Symfi, Symfi Lo)
□ Etravirine (e.g., Intelence)
□ Fosamprenavir (e.g., Lexiva)
□ Indinavir (e.g., Crixivan),
□ Oral Ketoconazole
□ Lopinavir (e.g., Kaletra)
□ Modafinil
□ Nafcillin
□ Nelfinavir (e.g., Viracept),
□ Nevirapine (e.g., Viramune, Viramune XR)
□ Rifampin
□ Ritonavir (e.g., Kaletra, Norvir, Technivie, Viekira Pak, Viekira XR)
□ Rosuvastatin >10mg/day
□ Saquinavir (e.g., Fortovase, Invirase)
□ St. John's Wort
□ Tipranavir (e.g., Aptivus)
□ NONE

**Ribavirin**

□ Pregnancy
□ Member with pregnant partner
□ Hemoglobinopathies (e.g., thalassemia major, sickle-cell anemia)
□ Didanosine (Videx, Videx EC)
□ Stavudine (Zerit, Zerit XR)
□ Zidovudine (Retrovir, Combivir, Trizivir)
□ Autoimmune Hepatitis (Rebetol only)
□ Creatinine Clearance <50ml/min (Rebetol only)
□ NONE

**Mavyret**

□ Severe hepatic impairment (CTP Class C)
□ Atazanavir (e,g., Evotaz, Reyataz)
□ Atorvastatin
□ Carbamazepine
□ Darunavir (e.g., Prezcobix, Prezista)
□ Efavirenz (e.g., Atripla, Sustiva, Symfi, Symfi Lo)
□ Ethinyl estradiol (e.g., combined oral contraceptives)
□ Etravirine (e.g, Intelence)
□ Lopinavir (e.g., Kaletra)
□ Lovastatin
□ Requiring stable doses of Cyclosporine >100mg/day
□ Rifampin
□ Ritonavir (e.g., Kaletra, Norvir, Technivie, Viekira Pak, Viekira XR)
□ Rosuvastatin >10 mg/day
□ Simvastatin (e.g., Juvisync, Vytorin, Zocor)
□ St. John's wort (*Hypericum perforatum*)
□ NONE

**Epclusa**

□ Amiodarone without cardiac monitoring
□ Carbamazepine, phenytoin, phenobarbital, oxcarbazepine
□ Efavirenz (e.g., Atripla, Sustiva, Symfi, Symfi Lo)
□ Etravirine (i.e, Intelence)
□ Famotidine >40mg twice daily, Cimetidine >1600mg /day, Nizatidine >300mg/day, Ranitidine >600mg/day
□ Nevirapine
□ Proton Pump Inhibitor: provide name and strength: _____________________
□ Rifabutin, rifampin, rifapentine
□ Rosuvastatin >10mg/day
□ St. John's Wort
□ Tenofovir disoproxil fumarate (e.g., Atripla, Complera, Stribild, Truvada, Viread) if eGFR is <60mL/min
□ Tipranavir (e.g., Aptivus)
□ Topotecan
□ NONE

**Harvoni**

□ Amiodarone without cardiac monitoring
□ Carbamazepine
□ Elvitegravir/cobicistat/emtricitabine/ tenofovir disoproxil fumarate (Stribild)
□ H2-antagonists that exceed doses comparable to Famotidine >40mg twice daily (i.e., Cimetidine >1600mg /day, Nizatidine >300mg/day, Ranitidine >600mg/day)
□ Oxcarbazepine
□ Phenobarbital
□ Phenytoin
□ Proton Pump Inhibitors that exceed doses comparable to Omeprazole >20mg daily (i.e., Dexlansoprazole >60mg/day, Lansoprazole >30mg/day, Pantoprazole >40mg/day, Esomeprazole >40mg/day, Rabeprazole >20mg/day)
□ Rifabutin, rifampin, or rifapentine
□ Rosuvastatin (Crestor)
□ Simeprevir (Olysio)
□ St. John's Wort (Hypericum perforatum)
□ Tipranavir (Aptivus)
□ NONE

**Vosevi**

□ Amiodarone without cardiac monitoring
□ Atazanavir (e,g., Evotaz, Reyataz)
□ Carbamazepine, phenytoin, phenobarbital, oxcarbazepine
□ Cyclosporine
□ Efavirenz (e.g., Atripla, Sustiva, Symfi, Symfi Lo)
□ Etravirine (i.e, Intelence)
□ H2-antagonists that exceed doses comparable to Famotidine >40mg twice daily (i.e., Cimetidine >1600mg /day, Nizatidine >300mg/day, Ranitidine >600mg/day)
□ Lopinavir (e.g., Kaletra)
□ Nevirapine
□ Omeprazole >20mg daily
□ Pitavastatin
□ Pravastatin >40mg/day
□ Rifabutin, rifampin, rifapentine
□ Rosuvastatin
□ St. John's Wort (*Hypericum perforatum*)
□ Tipranavir (e.g., Aptivus)
□ NONE

**Physician office's signature*_________________________________ Print Name________________________________**

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

24, cont'd. **For each drug being requested, please indicate if member has any of the listed conditions or is taking any of the listed drugs.**

**Sovaldi**

□ Amiodarone without cardiac monitoring
□ Carbamazepine
□ Oxcarbazepine
□ Phenobarbital
□ Phenytoin
□ Rifabutin, rifampin, or rifapentine
□ St. John's Wort (Hypericum perforatum)
□ Tipranavir (Aptivus)
□ NONE

**Pegasys, Peg-Intron, Intron-A**

□ Autoimmune Hepatitis
□ Hepatic decompensation or decompensated liver disease
□ NONE

**Viekira Pak**

□ Moderate hepatic impairment (CTP class B)
□ Severe hepatic impairment (CTP Class C)
□ HIV-coinfected members who are not taking antiretroviral therapy
□ Alfuzosin
□ Carbamazepine, phenytoin, phenobarbital
□ Darunavir (e.g., Prezcobix, Prezista),
□ Efavirenz (e.g., Atripla, Sustiva, Symfi, Symfi Lo)
□ Ergotamine, dihydroergotamine, ergonovine, methylergonovine
□ Ethinyl estradiol-containing medications (e.g., combined oral contraceptives)
□ Gemfibrozil
□ Ketoconazole >200mg/day
□ Known hypersensitivity to ritonavir (e.g. toxic epidermal necrolysis, Stevens-Johnson syndrome)
□ Lopinavir/ritonavir (e.g., Kaletra)
□ Lovastatin, simvastatin
□ Omeprazole >40mg/day
□ Pimozide (Orap)
□ Rifampin
□ Rilpivirine once daily (e.g., Complera, Edurant, Juluca, Odefsey)
□ Rosuvastatin >10mg/day, Pravastatin >40mg/day
□ Salmeterol (e.g., Airduo, Advair, Serevent)
□ Sildenafil when dosed as Revatio® for the treatment of PAH
□ St. John's Wort (Hypericum perforatum)
□ Triazolam; orally administered midazolam
□ Voriconazole (unless prescriber states the benefit-to-risk ratio justifies the use of voriconazole)
□ NONE

**Daklinza**

□ Amiodarone
□ Carbamazepine
□ Dabigatran (Pradaxa) if CrCl <50ml/min
□ Phenytoin
□ Rifampin
□ St. John's wort (Hypericum perforatum)
□ NONE

**Physician office's signature*________________________________ Print Name________________________________**

***Form must be completed and signed by physician or licensed representative from the physician's office**