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: _____
□ Zepatier 50-100mg once daily		□ 12 weeks	□24 weeks	□ 16 weeks	□ Other: _____
□ Epclusa 400-100mg once daily (Please also fill out brand form)		□ 12 weeks	□24 weeks	□ 16 weeks	□ Other: _____
□ Sofosbuvir/Velpatasvir 400-100mg once daily		□ 12 weeks	□24 weeks	□ 16 weeks	□ Other: _____
□ Mavyret 3 tablets daily	□ 8 weeks	□ 12 weeks	□24 weeks	□ 16 weeks	□ Other: _____
□ Vosevi 400-100-100mg once daily		□ 12 weeks	□24 weeks	□ 16 weeks	□ Other: _____
□ Other: _____		□ 12 weeks	□24 weeks	□ 16 weeks	□ Other: _____

2. For ribavirin requests, please answer the following questions:
   a. Is the member or their partner pregnant? **Yes or No**
   b. Is the member or their partner of childbearing age? **Yes or No**
   - If **Yes,** has the member been or will be instructed to practice effective contraception during therapy and for 6 months after stopping ribavirin therapy? **Yes or No**

3. What is the member's weight? _____lbs ____kg

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)? _____
   - 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. Is the member HIV positive? **Yes or No**

10. 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).**

11. Has the member had an organ transplant? **Yes or No**
   *If yes, date of transplant_____ Which organ? _____

Physician office's signature*_____ Print Name_____
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12. 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**

13. 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.**

14. 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.

_____

_____

_____

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

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

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Physician office's signature*_____ Print Name_____

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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, which are contraindicated.**

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

□ Moderate or Severe hepatic impairment (CTP Class B or C)
□ History of prior hepatic decompensation
□ 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
□ Nevirapine (Viramune)
□ Phenytoin
□ 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) together with Ritonavir (e.g., Kaletra, Norvir, Viekira Pak)
□ 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)□ St. John's Wort (Hypericum perforatum)
□ Tipranavir (Aptivus) together with Ritonavir (e.g., Kaletra, Norvir, Viekira Pak)
□ 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) together with Ritonavir (e.g., Kaletra, Norvir, Viekira Pak)
□ NONE

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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, which are contraindicated.**

Sovaldi

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

Pegasys, 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)
□ Alfuzosin
□ Apalutamide
□ Atorvastatin
□ Carbamazepine, phenytoin, phenobarbital
□ Cisapride
□ Colchicine in patients with renal and/or hepatic impairment
□ Dronedarone (Multaq)
□ Darunavir/ritonavir 600/100mg twice daily in treatment experienced members with at least one darunavir resistance associated substitution or with no baseline resistance information
□ Efavirenz (e.g., Atripla, Sustiva, Symfi, Symfi Lo)
□ Ergotamine, dihydroergotamine, methylergonovine
□ Ethinyl estradiol-containing medications (e.g., combined oral contraceptives)
□ Everolimus, sirolimus, tacrolimus
□ Gemfibrozil
□ Ketoconazole >200mg/day
□ Known hypersensitivity to ritonavir (e.g. toxic epidermal necrolysis, Stevens-Johnson syndrome)
□ Lopinavir/ritonavir (e.g., Kaletra)
□ Lomitapide
□ Lurasidone (Latuda)
□ Lovastatin, simvastatin
□ Omeprazole >40mg/day
□ Pimozide (Orap)
□ Ranolazine
□ 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

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