CenCal HEALTH®
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MedImpact

Medication Request Form

Phone: 1-800-788-2949 Fax: 858-790-7100

Hepatitis C Therapy
Sofosbuvir/Velpatasvir (Epclusa™)
sbuvir/Velpatasvir/Voxilaprevir (Vosevi™)
Ribavirin

Instructions: This form is to be used by providers to obtain coverage of Hepatitis C therapy. Please complete this form and fax to MedImpact Healthcare Systems, Inc. at (858) 790-7100. Please provide supplemental documentation (e.g. chart notes, lab reports) of the patient's baseline HCV-RNA level, and any addition documentation that is relevant to the request.

If you have any questions regarding this process, please contact MedImpact's Customer Service at (800) 788-2949.

PATIENT INFORMATION	PRESCRIBER INFORMATION	
Name:	**Name:**	
ID#:	**Specialty:**	
Date of Birth:	**Prescriber NPI#::**	
Baseline HCV-RNA:	**Phone: ( ) -**	**Fax:** ( ) -
PHARMACY INFORMATION		
Pharmacy Name:	**Phone:** ( ) -	**Fax:** ( ) -

REQUESTED THERAPY

Preferred Agents:

- ☐ Sofosbuvir/Velpatasvir: 1 tablet daily
- ☐ Vosevi: 1 tablet daily
- ☐ Ribavirin: _____

Non-Preferred Drug Request:

Drug Name and Dose: _____

Clinical Justification: _____

Length of Treatment _____ weeks

Please list any other Hepatitis C therapy that the patient will use in addition to the requested therapy above:

Please answer the following questions:	Yes	No
1. Does the patient have any of the following conditions? *(check all that apply)* *If yes, please continue to #2, otherwise continue to #3* ☐ Recurrent HCV infection post-liver transplantation ☐ HIV coinfection ☐ Renal impairment (GFR < 30mL/min/1.73m^2) ☐ End state renal disease requiring dialysis ☐ Kidney transplant recipient ☐ HCV-uninfected transplant recipient receiving organs from HCV-viremic donors ☐ Compensated cirrhosis ☐ Decompensated cirrhosis ☐ HIV coinfection ☐ HCV in pregnancy ☐ HCV in children	○	○
2. Please provide the patient's HCV genotype (and if available the fibrosis score), then continue to #3. HCV Genotype: _____		

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	Yes	No
3. Does the patient have a limited life expectancy (less than 12 months) due to non-liver-related conditions OR liver related conditions that cannot be remediated by HCV therapy, liver transplantation, or another directed therapy?	◯	◯
4. Does the patient have a short life expectancy due to a liver disease?	◯	◯
5. Has the patient been evaluated for readiness to initiate treatment? If so, is the patient able and willing to strictly adherence to the treatment protocols prescribed?	◯	◯
6. Has the patient been educated regarding potential risks and benefits of Hepatitis C therapy, as well as the potential for resistance and failed therapy if therapy is not taken as prescribed?	◯	◯
7. Is the request for an FDA-approved regimen or a regimen recommended by the AASLD? *If no, please continue to #8, otherwise continue to #9*	◯	◯
8. Investigational request: (Check all that apply) ☐ Conventional therapy will not adequately treat the intended patient's condition ☐ Conventional therapy will not prevent progressive disability or premature death ☐ The provider of the proposed service has a record of safety and success with it equivalent or superior to that of other providers of the investigational service ☐ The investigational service is the lowest cost item or service that meets the patient's medical needs and is less costly than all conventional alternatives ☐ The service is not being performed as a part of a research study protocol ☐ There is a reasonable expectation that the investigational service will significantly prolong the intended patient's life or will maintain or restore a range of physical and social function suited to activities of daily living. ☐ Requested unlabeled use represents reasonable and current prescribing practices. The determination of reasonable and current prescribing practices shall be based on: 1) reference to current medical literature and 2) consultation with provider organizations, academic and professional specialists. Additional justification: _____	◯	◯
9. Is the request for a patient that previously failed Hepatitis C treatment? *If yes, what was the previously failed therapy?* _____	◯	◯
10. Does the patient have a history of treatment failure with prior hepatitis C treatment due to nonadherence with the treatment regimen and appointments?	◯	◯