Trillium Health Resources
Pharmacy Prior Approval Request for

Hepatitis C: Epclusa

Member Information

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

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: **Epclusa** 2. Strength: _____ 3. Quantity per 30 Days: 28 _____
4. Length of Therapy (in days): ☐ 12 Weeks ☐ 24 Weeks

Clinical Information

Total Length of Therapy (Check ONE):

☐ 12 weeks = Genotype 1, 2, 3, 4, 5, or 6 treatment naïve and treatment experienced without cirrhosis and with compensated cirrhosis (Child Pugh A) or treatment-naïve and treatment-experienced liver transplant recipients without cirrhosis or with compensated cirrhosis (Child-Pugh A)

☐ 12 weeks with ribavirin = Genotypes 1,2,3,4,5, or 6 treatment- naïve and treatment -experienced with decompensated cirrhosis (Child-Pugh B and C)

☐ 24 weeks = Genotypes 1,2,3,4,5 or 6 treatment- naïve and treatment -experienced with decompensated cirrhosis (Child-Pugh B and C) and are ribavirin ineligible

1. What is the member's Genotype? _____

2. Is the member is 3 years if age or older with a diagnosis of chronic hepatitis C (CHC) infection with genotype 1, 2, 3, 4, 5 or genotype 6 without cirrhosis or with compensated cirrhosis or with decompensated cirrhosis?

☐ Yes ☐ No

3. As the provider, are you reasonably certain that treatment will improve the member's overall health status?

☐ Yes ☐ No

4. Does the member have FDA labeled contraindications to Epclusa? ☐ Yes ☐ No

5. Is Epclusa is being used in combination with other drugs containing sofosbuvir? ☐ 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 PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277