Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Hepatitis C: Viekira Pak

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: **Viekira** 2. Strength: _____ 3. Quantity per 30 Days 112
4. Length of Therapy (in days): ☐ 365 Days

Clinical Information

Total Length of Therapy (Check ONE):

☐ **12 weeks** = Genotype 1a, without cirrhosis, or genotype 1b, with cirrhosis

☐ **24 weeks** = Genotype 1a, with compensated cirrhosis

1. What is the member's Genotype? _____
2. Is the member is 18 years of age or older with a diagnosis of chronic hepatitis C (CHC) infection with confirmed genotype 1b without cirrhosis or with compensated cirrhosis or confirmed genotype 1a without cirrhosis or with compensated cirrhosis in combination with ribavirin? ☐ **Yes** ☐ **No**
3. For all treatment courses except genotype 1b, will treatment include the use of ribavirin? ☐ **Yes** ☐ **No**
4. As the provider, are you reasonably certain that treatment will improve the member's overall health status? ☐ **Yes** ☐ **No**
5. Has the provider assessed for laboratory and clinical evidence of hepatic decompensation? ☐ **Yes** ☐ **No**
6. Does the member have cirrhosis? ☐ **Yes** ☐ **No** If answer is yes, please answer the following:
   6a. Is the member being monitored for clinical signs and symptoms of hepatic decompensation (such as ascites, hepatic encephalopathy, variceal hemorrhage)? ☐ **Yes** ☐ **No**
   6b. Has the member 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**
7. 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**
8. Is the member using Viekira Pak in combination with another NS5A inhibitor? ☐ **Yes** ☐ **No**
9. Is the member 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**
10. Is the member 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**

Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277

11. Does the member 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**
12. Has the member attempted a previous course of therapy with Viekira Pak? ☐ **Yes** ☐ **No**
13. Does the member have any FDA labeled contraindications to Viekira Pak? ☐ **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.