Trillium Health Resources
Pharmacy Prior Approval Request for

Hepatitis C: Zepatier

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: **Zepatier** 2. Strength: _____ 3. Quantity per 30 Days: 28
4. Length of Therapy (in days): ☐ 365 days

Clinical Information

Total Length of Therapy (Check ONE):

☐ **12 weeks** = Genotype 1a and treatment naïve or PegIFN/RBV-experienced without baseline NS5A polymorphisms; genotype 1b and treatment naïve or PegIFN/RBV-experienced; Genotype 1a or 1b and PegIFN/RBV/PI-experienced; or Genotype 4 and treatment-naïve.

☐ **16 weeks** = Genotype 1a and treatment-naïve or PegIFN/RBV-experienced with baseline NS5A polymorphisms; or Genotype 4 and PegIFN/RBV-experienced.

1. What is the member's Genotype? _____
2. Is the member 12 years of age or older or weigh >30kg with a diagnosis of chronic hepatitis C (CHC) with genotype 1 or genotype 4? ☐ **Yes** ☐ **No**
3. Is the member being prescribed Zepatier in conjunction with ribavirin if he/she has a genotype 1a baseline NS5A polymorphisms, genotype 1a or 1b who are treatment experienced with Peginterferon alfa + ribavirin + HCV NS3/4A protease inhibitor or genotype 4 who are treatment experienced with Peginterferon alfa + ribavirin?
   ☐ **Yes** ☐ **No**
4. Is Zepatier being prescribed with ribavirin? ☐ **Yes** ☐ **No**
5. As the provider, are you reasonably certain that treatment will improve the member's overall health status?
   ☐ **Yes** ☐ **No**
6. Does the member have FDA labeled contraindications to Zepatier? ☐ **Yes** ☐ **No**
7. Does the member have moderate to severe hepatic impairment (child-pugh B or C) or any history of prior hepatic decompensation? ☐ **Yes** ☐ **No**
8. Is Zepatier being co administered with organic anion transporting polypeptides 1B1/3 (OATP1B1/3) inhibitors, strong inducers of cytochrome P450 3A (CYP3A), or efavirenz. ☐ **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