Louisiana Health Access Program (LA HAP) – Uninsured Patients
Supplemental Form for Hepatitis C Treatment Regimens
RAMSELL TELEPHONE: 1-888-311-7632 RAMSELL FAX: 1-800-848-4241

Please complete the appropriate sections below for determination of treatment authorization.

A response is provided to the pharmacy and/or prescriber within 24-48 business hours.

☐ **PA required for LA HAP uninsured member ONLY.**

Patient Name_____ (Last Name First Name)

Member ID _____

DOB_____ Height _____Weight_____

CD4 count_____ HIV viral load _____

Baseline Hepatitis RNA: _____

_____ (Signature of pharmacist or physician Date)

Prescribing Physician _____

Prescriber NPI # _____ Specialty_____

Physician Phone # _____Fax#_____

Pharmacy Name _____

NPI# _____Contact Person_____

Pharmacy Phone# _____Fax# _____

Click for Uninsured Pharmacy Locator

By signing above, you attest that all statements on this form are true to the best of your knowledge.

Supporting labs are REQUIRED for approval of this request. (HCV genotype and viral load)

REQUIRED DOCUMENTATION - Please submit the following lab results with PA form:

☐ Hepatitis C Genotype ☐ Hepatitis C RNA viral load (within the last 12 months)

Does this patient have diagnosis of Chronic Hepatitis C? ☐ Yes ☐ No

What is the Hepatitis C Genotype? (circle): 1a 1b 2 3 4 5 6

Has this patient been treated for Hepatitis C previously? (Check all that apply)

☐ None (Treatment naïve)

☐ If yes, provide drug name, duration of therapy, last treatment date:

_____

What is the planned treatment regimen and duration? (Please select treatment and provide dosing and duration):

☐ Elbasvir-grazoprevir (**Zepatier®**) Dosing: _____ Duration: ____weeks

☐ Glecaprevir-pibrentasvir (**Mavyret®**) Dosing: _____ Duration: ____weeks

☐ Ledipasvir-sofosbuvir (**Harvoni®**) Dosing: _____ Duration: ____weeks

☐ Ombitasvir-paritaprevir-ritonavir-dasabuvir (**Viekira Pak®**) Dosing: _____ Duration: ____weeks

☐ Sofosbuvir (**Sovaldi®**) Dosing: _____ Duration: ____weeks

☐ Sofosbuvir-velpatasvir (**Epclusa®**) Dosing: _____ Duration: ____weeks

☐ Sofosbuvir-velpatasvir-voxilaprevir (**Vosevi®**) Dosing: _____ Duration: ____weeks

If the patient has advanced liver disease, please answer the following questions. (Circle)

☐ Does this patient have a history of cirrhosis? YES NO

☐ Does this patient have decompensated liver disease? YES NO

Prescriber Acknowledgement

☐ I agree to submit HCV RNA result from 4 (or 12) weeks after treatment completion for program evaluation purposes (FAX to Ramsell)

☐ I have reviewed the clinical information on the proposed prescription for possible drug-drug interactions with other medications currently prescribed to the patient