Louisiana Health Access Program (LA HAP) – Uninsured and Medicaid Patients
Supplemental Form for Hepatitis C Treatment Regimens
TELEPHONE LA HAP: 504-568-7474 FAX LA HAP: 504-568-3157

Please complete the appropriate sections below for determination of treatment authorization

☐Medicaid/LA HAP Member ☐LA HAP member ONLY

Patient Name____ Prescribing Physician ____
Last Name First Name

Prescriber NPI # _________________________ Specialty _______________

Member ID ____ Physician Phone # ______________________Fax#____________________

DOB_________________ Height __________Weight____________ Pharmacy Name# ____

CD4 count ______________ HIV viral load ______________ NABP# _________________________Contact Person___________________

Baseline Hepatitis RNA: ______________________________ Pharmacy Phone# ______________________Fax# ____________________

____
Signature of pharmacist or physician Date

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

All supporting labs and chart documentation are REQUIRED for approval of this request.

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

Serum marker of Fibrosis (FibroSure®): ☐ N/A ☐ F0 – F1(0.00-0.31) ☐ F1-F2 (0.31 – 0.58) ☐ F3-F4 (0.58 – 1.00)

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

- ☐ None (Treatment naïve)
- ☐ Prior relapse to PEG/ribavirin Date:____________________
- ☐ Prior partial responder to PEG/ribavirin Date:____________________
- ☐ Prior null responder to PEG/ribavirin Date:____________________
- ☐ Prior failure on telaprevir (Incivek®) or boceprevir (Vitrelis®) Date:____________________

What is the planned treatment regimen and duration? (Please fill in):

- ☐ Drug Name(s) including strength :
  ____
- ☐ Daily Dosing: ____
- ☐ Duration of therapy (weeks):

Please confirm the following statements: (check all that apply)

- ☐ This patient is on a stable antiretroviral regimen for HIV with HIV viral load < 200 copies/mL
- ☐ This patient has failed multiple trials of antiretroviral therapy due to advanced liver disease precluding antiretroviral treatment prior to HCV treatment.

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

For All

- ☐ 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

REQUIRED DOCUMENTATION - Please submit ALL required clinical notes/ lab reports in reference to this request. Failure to provide documentation will delay decision process.

☐ Hepatitis C Genotype ☐ Hepatitis C RNA viral load (within the last 3 months) ☐ CD4 count (within the last 6 months) ☐ HIV viral load (within the last 6 months) ☐ **As Needed**- Fibrosis staging results-FiborTest/FibroSure® (within the last 6 months)