Nevada Medication Assistance Program (NMAP)
Supplemental Form for Hepatitis C Treatment Regimens
TELEPHONE: 888-311-7632 FAX: 800-848-4241

Please complete the appropriate sections below for determination of treatment authorization

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# _____

_____ _____ _____ _____
Name of pharmacist or physician Date 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 a 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)
- ☐ Prior PEG/ribavirin regimen Date:_____
- ☐ Prior NS5A Inhibitor DAA experienced – Drug: _____ Date: _____
- ☐ Prior Non-NS5A Inhibitor, Sofosbuvir-containing regimen Date: _____
- ☐ Prior NS3 Protease Inhibitor (telaprevir (Incivek®), boceprevir (Vitrelis®), or simeprevir (Olysio®) + PEG/Ribavirin experienced 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.
- ☐ This patient has been tested for current or prior HBV infection (if treating with DAA)

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 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

Submit: Please fax completed application to Ramsell at **800-848-4241**.
For additional information, call the Ramsell Help Desk at: 1-888-311-7632.