Ramsell

Washington Early Intervention Program (EIP)
Supplemental Form for Hepatitis C Treatment Regimens
TELEPHONE: 888-311-7632 FAX: 800-848-4241

Please complete the appropriate sections listed below for determination of treatment authorization.
Please provide the baseline absolute CD4 count, HIV and HCV viral loads and all supporting lab documents for review.

Patient Name_____ Prescribing Physician _____
Last Name First Name
ADAP ID Code_____ Physician DEA # _____

DOB_____ Height _____Weight_____ Physician Phone # _____Fax#_____

Latest CD4 count &Viral Load_____/_____ Pharmacy Name_____

Date of results: _____ NABP# _____Contact Person_____

_____ Pharmacy Phone# _____Fax# _____
Signature of pharmacist or physician Date

NOTE TO PHYSICIAN: Please be aware Hepatitis C (HCV) treatment approval requires that the client's WA EIP eligibility end date is on or after the end date of HCV treatment. You will be advised accordingly.

Medical Justification - Completion of all questions 1-4 with documentation are REQUIRED for approval

HCV genotype (circle): 1a 1b 2 3 4 5 6

1. **Prior HCV treatment (check): (Note: See Section 2.1 of simeprevir package insert for definition of prior relapse, partial and null responders)**
   - ☐ None (treatment naïve)
   - ☐ Prior relapse to PEG/ribavirin
   - ☐ Prior partial responder to PEG/ribavirin
   - ☐ Prior null responder to PEG/ribavirin
   - ☐ Prior failure on telaprevir (Incivek®) or boceprevir (Victrelis®)

2. **Planned HCV treatment regimen and duration (check all that apply):**
   - ☐ daclatasvir (Daklinza®) 30mg, 60mg or 90mg tablet orally once daily for ____ weeks
   - ☐ elbasvir-grazoprevir (Zepatier®) 1 tablet orally once daily for ____ weeks
   - ☐ ledipasvir-sofosbuvir (Harvoni®) 1 tablet orally once daily for ____ weeks
   - ☐ ombitasvir 12.5 mg/paritaprevir 75 mg/ritonavir 50 mg (Technivie®) 2 tablets orally once daily for ____weeks
   - ☐ ombitasvir-paritaprevir-ritonavir-dasabuvir (Viekira Pak®) _____weeks
   - ☐ sofosbuvir (Sovaldi®) 400mg orally once daily for _____ weeks
   - ☐ sofosbuvir-velpatasvir (Epclusa®) 400mg-100mg once daily for ____ weeks
   - ☐ simeprevir (Olysio®) 150mg orally once daily with food for _____weeks
   - ☐ peginterferon alfa-2a (PEGASYS®) 180mcg subQ weekly for ____ weeks
   - ☐ peginterferon alfa-2b (PegIntron®) 1.5mcg/kg subQ weekly for _____ weeks
   - ☐ weight-based ribavirin (< 75kg: 500mg orally BID; > 75kg: 600mg orally BID) for _____weeks

3. **WA EIP will require all of the following except where indicated (check all that apply):**
   - ☐ On a stable antiretroviral regimen for HIV with HIV viral load < 200 copies/mL for at least 8 weeks (submit copy of viral load result to Ramsell)

   OR
   - ☐ Failed multiple trials of antiretroviral therapy due to advanced liver disease precluding antiretroviral treatment prior to HCV treatment (submit medical documentation to Ramsell)

   OR
   - ☐ History of cirrhosis (submit fibrosis staging and/or liver biopsy results to Ramsell)

4. **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.
   - ☐ I agree to submit HCV RNA viral load result from 12 weeks after treatment completion for program evaluation purposes (FAX to Ramsell).