WellCare

NC Medicaid
Pharmacy Prior Approval Request for

Viekira

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext._____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: 112
11. Length of Therapy (in days): ☐ 12 weeks ☐ 24 Weeks

Clinical Information

Total Length of Therapy (Check ONE):

☐ **12 weeks** = Genotype 1a, without cirrhosis, or genotype 1b, with cirrhosis

☐ **24 weeks =** Genotype 1a, with compensated cirrhosis

1. Is the beneficiary is 18 years of age or older with a diagnosis of chronic hepatitis C (CHC) infection with confirmed genotype 1 b without cirrhosis or with compensated cirrhosis or confirmed genotype 1a without cirrhosis or with compensated cirrhosis in combination with ribavirin? ☐ **Yes** ☐ **No**

   Genotype is: _____
2. For all treatment courses except genotype 1b (without cirrhosis), will treatment include the use of ribavirin?

   ☐ **Yes** ☐ **No**
3. As the provider, are you reasonably certain that treatment will improve the beneficiary's overall health status?

   ☐ **Yes** ☐**No**
4. Has the provider assessed for laboratory and clinical evidence of hepatic decompensation? ☐ **Yes** ☐ **No**
5. Does the beneficiary have cirrhosis? ☐ **Yes** ☐ **No** If answer is yes, please answer the following:

   5a. Is the beneficiary being monitored for clinical signs and symptoms of hepatic decompensation (such as ascites, hepatic encephalopathy, variceal hemorrhage)? ☐ **Yes** ☐ **No**

   5b. Has the beneficiary received hepatic laboratory testing including direct bilirubin levels at baseline and during the first four weeks of starting treatment and as clinically indicated? ☐ **Yes** ☐ **No**
6. Is Viekira Pak being used in combination with other protease inhibitors used to treat CHC (i.e. boceprevir, simeprevir, or telaprevir) or in combination with another nucleotide NS5B polymerase inhibitor such as Sovaldi® (sofosbuvir)?

   ☐ **Yes** ☐ **No**
7. Is the beneficiary using Viekira Pak in combination with another NS5A inhibitor? ☐ **Yes** ☐ **No**
8. Is the beneficiary requesting the regimen for re-treatment and either failed to achieve a SVR (defined as a lower limit HCV RNA of 25 IU/mL) or relapsed after achieving a SVR during a prior successfully completed treatment regimen consisting of Sofosbuvir?☐**Yes** ☐ **No**
9. Is the beneficiary requesting the regimen for re-treatment and either failed to achieve a SVR (defined as a lower limit HCV RNA of 25 IU/mL) or relapsed after achieving a SVR during a prior successfully completed treatment regimen consisting of Ledipasvir? ☐ **Yes** ☐ **No**
10. Does the beneficiary have decompensated liver disease as defined by Child-Pugh classification score of Child Class B or C (VIEKIRA PAK™ is contraindicated in beneficiaries with moderate to severe hepatic impairment (Child-Pugh B and C)? ☐**Yes** ☐ **No**

Fax this form to CSRA at (855) 710-1969
DHB Pharmacy 34
10.20.2023

Pharmacy PA Call Center: (866) 246-8505

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11. Is the beneficiary requesting the regimen for re-treatment and either failed to achieve a SVR (defined as a lower limit HCV RNA of 25 IU/mL) or relapsed after achieving a SVR during a prior successfully completed treatment regimen consisting of Ledipasvir? ☐ **Yes** ☐ **No**
12. Does the beneficiary have decompensated liver disease as defined by Child-Pugh classification score of Child Class B or C (VIEKIRA PAK™ is contraindicated in beneficiaries with moderate to severe hepatic impairment (Child-Pugh B and C)? **Yes** ☐ **No**
13. Has the beneficiary attempted a previous course of therapy with Viekira Pak? ☐ **Yes** ☐ **No**
14. Does the beneficiary have any FDA labeled contraindications to Viekira Pak? ☐ **Yes** ☐ **No**
15. Has the beneficiary tried and failed 2 preferred medications in this class or does the beneficiary have a reason or contraindication to the preferred medications in the class? ☐ **Yes** ☐ **No** Please list t/f medications and/or any contraindications to the preferred medications:
    _____
    _____
    _____

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.