WellCare

NC Medicaid

Pharmacy Prior Approval Request for

Zepatier

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: _____
11. Length of Therapy (in days): ☐ 12 weeks ☐ 16 weeks

Clinical Information

☐ **12 weeks =** Genotype 1a and treatment naïve or PegIFN/RBV-experienced without baseline NS5A polymorphisms; genotype 1b and treatment naïve or PegIFN/RBV-experienced; Genotype 1a or 1b and PegIFN/RBV/PI-experienced; or Genotype 4 and treatment-naïve.

☐ **16 weeks** = Genotype 1a and treatment-naïve or PegIFN/RBV-experienced with baseline NS5A polymorphisms; or Genotype 4 and PegIFN/RBV-experienced.

1. Is the beneficiary 18 years of age or older with a diagnosis of chronic hepatitis C (CHC) with genotype 1 or genotype 4?
   ☐ **Yes** ☐ **No** **Genotype is:** _____
2. Is the beneficiary being prescribed Zepatier in conjunction with ribavirin if he/she has a genotype 1a baseline NS5A polymorphisms, genotype 1a or 1b who are treatment experienced with Peginterferon alfa + ribavirin + HCV NS3/4A protease inhibitor or genotype 4 who are treatment experienced with Peginterferon alfa + ribavirin? ☐ **Yes** ☐ **No**
3. As the provider, are you reasonably certain that treatment will improve the beneficiary's overall health status?
   ☐ **Yes** ☐ **No**
4. Does the beneficiary have FDA labeled contraindications to Zepatier? ☐ **Yes** ☐ **No**
5. Does the Beneficiary have moderate to severe hepatic impairment (child-pugh B or C) or any history of prior hepatic decompensation?
   ☐ **Yes** ☐ **No**
6. Is Zepatier being co administered with organic anion transporting polypeptides 1B1/3 (OATP1B1/3) inhibitors, strong inducers of cytochrome P450 3A (CYP3A), or efavirenz. ☐ **Yes** ☐ **No**
7. 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.

Fax this form to CSRA at (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505

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