Medication Request Form (MRF)/Prescription Request
Viekira Pak
(ombitasvir, paritaprevir, and ritonavir tablets; dasabuvir tablets)

Instructions:
This form is a prescription order for Viekira Pak. This form is also to be used by participating physicians and pharmacy providers to obtain coverage of Viekira Pak. Please complete this form and fax to Health New England at (413) 233-2777 and please allow 3-15 days to process. If you have any questions regarding this process, please contact Health New England Member Services Department at (800) 310-2835.

Patient Information (all required)	Physician Information (all required)
Patient Name:	**Physician Name:** **Specialty:**
Patient Health New England ID#:	**Health New England Provider #:**
Patient Date of Birth:	**NPI #:**
Allergies:	**Telephone #: ( ) -**
Diagnosis:	**Fax #: ( ) -**

Drug Information

All genotype 1 HCV patients new to treatment or treatment experienced must use Viekira Pak prior to any alternative HCV treatment regimens (i.e. Harvoni) unless contraindicated.

Requested Drug/Strength/Form: ☐ **Viekira Pak** ☐ **Ribavirin** ☐ **12 weeks** ☐ **24 weeks**

Dosage Strength and Form (be specific):	Quantity (per month):	Refills:
☐ Viekira Pak (paritapreir/ritonavir/ombitasvir) Two tablets daily PLUS (dasabuvir) One tablet PO BID PLUS ribavirin where indicated ☐ Ribavirin	_____	_____

Physician Signature: **Date:**

☐ **Initial therapy:** 8 weeks

LABORATORY RESULTS REQUIRED FOR CONTINUATION OF THERAPY

☐ **Continuation of therapy for:** ☐ 4 additional weeks	**HCV-RNA level:** ***(please specify if undetectable)*** Baseline level: _____IU/mL Date:_____ Treatment week 4: _____IU/mL Date:_____

Indications:

☐ Hepatitis C virus (HCV) with genotype (G) 1 (mixed or unknown) : ☐ **1** ☐ **1a** ☐ **1b**

☐ Patient has a documented diagnosis of HCV with G 1 and is co-infected with human immunodeficiency virus (HIV) and has been adherent with antiretroviral therapy as evidenced by undetectable viral load

☐ Patient has a documented diagnosis of chronic infection with HCV G 1 and has had a liver transplant

Effective date: 2/10/2015

Documentation of Medical Necessity:

☐ *Treatment Naïve* ☐ *Treatment Experienced: Date Started:*_____ *Drugs:*_____

- ☐ Patient is 18 years of age or older
- ☐ Is the prescriber a gastroenterologist, hepatologist, or infectious disease physician? (please specify)_____
- ☐ Baseline laboratory results HCV RNA test, complete blood count (CBC), international normalized ratio (INR), hepatic function panel, and calculated glomerular filtration rate (GFR), within 6 weeks prior to initiating therapy
  HCV RNA Baseline: Date: _____ Result:_____ IU/ml or _____log
- ☐ Patient has not been previously treated (failed or relapsed) with a regimen consisting of a NS3/4A protease inhibitor [such as but not limited to Olysio (simeprevir), Incivek (telaprevir), Victrelis (boceprevir), or paritaprevir] in the past 2 years

For HCV Genotype 1, 1a, 1b:

- ☐ Patient has advanced liver disease as indicated by at least one of the following:
  - ☐ Liver biopsy: METAVIR or Batts-Ludwig stage 3 to 4 fibrosis (on a scale from 0 to 4) or Ishak stage 4 to 6 fibrosis (on a scale from 0 to 6) confirms the diagnosis of cirrhosis.
  - ☐ Ultrasound, CT or MRI indicative of surface abnormalities or portal hypertension and ascites
  - ☐ Liver fibrosis imaging:
    - ☐ Fibroscan value > 9.5 kPa
    - ☐ ARFI value of > 1.61 meters/second
    - ☐ FibroSure score > 0.58
  - ☐ Serum markers of fibrosis including:
    - ☐ APRI > 1.5 has been associated with advanced fibrosis (METAVIR F3-F4)
    - ☐ FIB-4 > 3.25 has been associated with advanced fibrosis (METAVIR F3-F4)

For all HCV Genotypes:

- ☐ Patient does **NOT** have decompensated liver disease (e.g., Child-Pugh Score $\geq$ 7, MELD score > 18) and/or clinical manifestations (e.g. bleeding varices, ascites, encephalopathy, jaundice, etc.) of advanced cirrhosis.
- ☐ Patient does not have significant or unstable cardiac disease
- ☐ Patient does not have ongoing non-adherence to previously scheduled appointments, prescribed medications or medical treatment
- ☐ Patient has completed HCV disease evaluation appointments and procedures and is willing to commit to scheduled monitoring for the duration of treatment
- ☐ Patient is currently eligible and willing to begin therapy
- ☐ Patient has been provided adherence counseling and patient understanding has been documented
- ☐ Patients who are known abusers of alcohol (AUDIT C Score $\geq$ 8) or illicit substances must have:
  - ☐ Been referred to an addiction specialist
  - ☐ Demonstrated abstinence of alcohol abuse or illicit substances for at least six months
  - ☐ Ongoing participation in a formal treatment program
  - ☐ Presence of adequate psychosocial supports as determined by social service and psychiatry consultants
- ☐ Women of childbearing potential receiving ribavirin or who have male partners receiving ribavirin (this applies to female patients or in female partners of male patients):
  - ☐ When **Viekira Pak** is used in combination with ribavirin therapy (which is pregnancy category X), it should not be started unless a report of a negative pregnancy test has been obtained immediately prior to initiation of therapy. Two effective methods of contraception should be used during treatment with Sovaldi™ and concomitant ribavirin, and for 6 months after treatment has concluded. Routine monthly pregnancy tests must be performed during this time.