

**State of Oklahoma
Oklahoma Health Care Authority
Daklinza™ (daclatasvir) Initiation Prior Authorization Form**

Member Name: _____ **Date of Birth:** _____ **Member ID#:** _____
Pharmacy NPI: _____ **Pharmacy Phone:** _____ **Pharmacy Fax:** _____
Pharmacy Name: _____ **Pharmacist Name:** _____
Prescriber NPI: _____ **Prescriber Name:** _____ **Specialty:** _____
Prescriber Phone: _____ **Prescriber Fax:** _____ **Drug Name:** _____
NDC: _____ **Start Date:** _____

Clinical Information

1. HCV Genotype (including subtype): _____ Date Determined: _____
2. METAVIR Equivalent Fibrosis Stage: _____ Testing Type: _____
Date Fibrosis Stage Determined: _____
3. Pre-Treatment Viral Load: _____ Date Determined: _____
4. Does member have decompensated hepatic disease (CTP class B or C)? Yes ___ No ___
5. Has the member been evaluated by a gastroenterologist, infectious disease specialist, or a transplant specialist within the past 3 months? Yes ___ No ___
6. If yes, please include name of specialist recommending hepatitis C treatment: _____
7. Has the member been previously treated for hepatitis C? Yes ___ No ___
8. If yes, please indicate previous treatment regimen and reason for failure (relapser, null-responder, partial responder): _____
9. Please indicate requested regimen below (a separate initiation form must be filled out for Sovaldi™):
 - Genotype 3, without cirrhosis: Daklinza™ 60mg with Sovaldi® x 84 days (12 weeks)
 - Genotype 3, with cirrhosis: Daklinza™ 60mg with Sovaldi® and ribavirin x 84 days (12 weeks)
 - Genotype 3 and concomitant use of a moderate CYP3A inducers: Daklinza™ 90mg with Sovaldi® x 84 days (12 weeks) *Moderate Inducers: bosentan, dexamethasone, efavirenz, etravirine, modafinil, nafcillin, and rifapentine*
 - Genotype 3 and concomitant use of a strong CYP3A inhibitor: Daklinza™ 30mg with Sovaldi® x 84 days (12 weeks) *Strong Inhibitors: atazanavir/ritonavir, clarithromycin, indinavir, itraconazole, ketoconazole, nefazodone, nelfinavir, posaconazole, saquinavir, telithromycin, and voriconazole*
 - Other: _____ **
10. Has the member signed the intent to treat contract**? Yes ___ No ___ ***Required for processing of request*
11. Has the member had illicit IV drug use or alcohol abuse in the last 6 months? Yes ___ No ___
12. Has the member initiated immunization with the hepatitis A and B vaccines? Yes ___ No ___
13. For women of childbearing potential (and male patients with female partners of childbearing potential):
 - Patient is not pregnant (or a male with a pregnant female partner) and not planning to become pregnant during treatment
 - Agreement that partners will use two forms of effective non-hormonal contraception during treatment (and for at least 6 months after completing treatment for ribavirin users)
Please list non-hormonal birth control options discussed with member _____
14. Is the member taking any of the following medications: amiodarone, carbamazepine, phenytoin, phenobarbital, rifampin, and St. John's wort? Yes ___ No ___
15. Have all other clinically significant issues been addressed prior to starting therapy? Yes ___ No ___

Members must be adherent for continued approval. Treatment gaps of therapy longer than 3 days will result in denial of payment for subsequent requests for continued therapy. Refills must be prior authorized.

Prescriber Signature: _____ **Date:** _____

Has the member been counseled on appropriate use of Daklinza™ therapy? Yes ___ No ___

Pharmacist Signature: _____ **Date:** _____

Please do not send in chart notes. Specific information/documentation will be requested if necessary. Failure to complete this form in full will result in processing delays.

| | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO: University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4</p> | <p align="center">CONFIDENTIALITY NOTICE</p> <p><i>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</i></p> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|