

**Viekira Pak™ (Ombitasvir/Paritaprevir/Ritonavir/Dasabuvir) 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 or moderate-to-severe hepatic impairment (Child-Pugh B or C)? Yes\_\_\_ No\_\_\_
5. Has the member been evaluated by a gastroenterologist, infectious disease specialist, or a transplant Specialist for hepatitis C therapy 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:
  - Genotype 1a, without cirrhosis: Viekira Pak™ with weight-based ribavirin x 84 days (12 weeks)
  - Genotype 1a with cirrhosis: Viekira Pak™ with weight-based ribavirin x 168 days (24 weeks)
  - Genotype 1b without cirrhosis: Viekira Pak™ x 84 days (12 weeks)
  - Genotype 1b with cirrhosis: Viekira Pak™ with weight-based ribavirin X 84 days (12 weeks)
  - 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  
Please list non-hormonal birth control options discussed with member \_\_\_\_\_
  - Verification that monthly pregnancy tests will be performed throughout treatment
14. Is the member taking any of the following medications: alfuzosin, carbamazepine, phenytoin, phenobarbital, gemfibrozil, rifampin, ergotamine, dihydroergotamine, ergonovine, methylergonovine, ethinyl estradiol, St. John's wort, lovastatin, simvastatin, pimozone, efavirenz, sildenafil, triazolam, midazolam? Yes\_\_\_ No\_\_\_
15. Have all other clinically significant issues been addressed prior to starting therapy? Yes\_\_\_ No\_\_\_
16. Will the member's ALT levels be monitored during the first four weeks of starting treatment and as clinically indicated thereafter? Yes\_\_\_ No\_\_\_

I recommend this patient be followed by an OHCA Care Management Nurse.

**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 Viekira Pak™ 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.*

**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

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