CMSP
COUNTY MEDICAL SERVICES PROGRAM

MedImpact Healthcare Systems, Inc.

Hepatitis C Treatment (Copegus®, Rebetol®, Peg-Intron®)
Medication Request Form
Phone: 1-800-788-2949, Fax: 858-790-7100

Member Name: _____ Member ID #: _____ DOB: _____

Prescriber Name: _____ Prescriber DEA#: _____ Prescriber Fax #: ( ) -

Prescriber's Signature (**Required**): _____ Prescriber Phone #: ( ) -

Requested Agent: ☐ Ribavirin 200mg (Dose:_____ tab or cap) ☐ Peg-Intron (Dose:_____)
Other ribavirin strengths are non-formulary *Pegasys is a non-formulary agent*

Protease inhibitors (Incivek, Victrelis, Olysio) and Sovaldi are not a covered benefit. These agents may be available through the drug manufacturer's patient assistance program. Additional information about drug company patient assistance programs is available on the internet at http://www.pparx.org/. Members who require combination therapy with a protease inhibitor or Sovaldi must obtain coverage by the drug manufacturer's patient assistance program prior to approval of pegylated interferon/ribavirin.

CMSP requires written documentation of ineligibility from the manufacturer's patient assistance program for consideration of coverage of pegylated interferon/ribavirin. A letter of denied eligibility from the drug manufacturer's patient assistance program must be faxed along with this completed form to MedImpact Healthcare Systems at (858) 790-7100. Members previously approved for Hepatitis C therapy by CMSP do not need to resubmit documentation of ineligibility.

Criteria for Initial Treatment

YES	NO	
		1. Will these agents be used with a protease inhibitor or Sovaldi? Members who require combination therapy with a protease inhibitor or Sovaldi must obtain coverage of these agents by the drug manufacturer's patient assistance program prior to approval of pegylated interferon/ribavirin.
		2. Does the patient have chronic hepatitis C? **What is the genotype?** _____
		3. Does the patient abuse alcohol or illicit injectable drugs? (If no, skip to #5.)
		4. If yes to #3, has the patient been actively participating in an alcohol or drug rehabilitation program and has been abstinent for at least the past 6 months?
		5. Does the patient meet ANY of the following criteria? • Short life expectancy (less than 10 years) • Known advanced cirrhosis with clinical decompensation (e.g., ascites, encephalopathy, variceal bleeding or SBP) • Pregnancy • Sexually active and unable to reliably use proper contraception • Inability to comply with medication instructions • Severe cardiac disease
		6. Does the patient meet ANY of the following criteria? (If no, skip to #8.) • History of suicide attempt or concrete ideation • History of hospitalization for moderate to severe psychiatric disease • Unstable psychiatric disease • Beck depression index >20
		7. If yes to #6, has the patient been evaluated by a Psychiatrist and cleared for Hepatitis C therapy?
		8. Does the patient meet ANY of the following criteria? (If no, skip to #10.) • Ultrasonographic evidence of cirrhosis or liver mass • Bilirubin > 1.5 (except in documented Gilbert's) • Any medical condition requiring or likely to require chronic administration of systemic corticosteroids • Child-Turcotte-Pugh Classification score of 6 or greater • Elevated creatinine • Abnormal TSH • Albumin < 3g/dL • Positive autoimmune test • Neutrophils < 1500 • WBC < 2500 • Platelets < 100,000 • Hgb < 12 in males and < 11 in females
		9. If yes to #8, has the patient been evaluated by a Gastroenterologist and cleared for Hepatitis C therapy?
		10. Has the patient been informed of the required duration of treatment and the potential adverse effects of therapy?
		11. Is the patient committed to completing the full course of therapy?

Renewal Criteria Requested approval duration: _____

YES	NO	
		1. Are these agents being used with a protease inhibitor or Sovaldi?
		2. Does the patient have genotype 1, 4, 5, or 6? (If yes, continue to #3. If no, please provide medical justification if requesting > 24weeks of treatment.)
		3. Has the patient already received 24 weeks of treatment for hepatitis C? (If yes, continue to #6. If no, continue to #4.)
		4. If no to #3, did the patient achieve a ≥ 2 log reduction in HCV RNA from baseline value in the first 12 weeks of treatment?
		5. Is the patient's HCV RNA detectable (> 50 IU/mL) at 12 weeks? (Do not continue to #6.)
		6. Is the patient HCV RNA undetectable (< 50 IU/mL) at 24 weeks?