SPECIAL AUTHORIZATION REQUEST FORM

The Newfoundland and Labrador Prescription Drug Program (NLPDP)

Request for Coverage of Harvoni®, Solvadi® and Ibavyr®

Pharmaceutical Services
Department of Health and Community Services
P.O. Box 8700, Confederation Bldg.
St. John's, NL A1B 4J6

Phone: (709) 729-6507
Toll Free Line: 1-888-222-0533
Fax: (709) 729-2851

Patient Information

Patient Name	Date of Birth	NLPDP Drug Card/MCP Number

Address

Diagnostic Information

Chronic Hepatitis C infection

Genotype: □ **1** □ **2** □ **3**

□ Patient has compensated liver disease (i.e. with no cirrhosis or with compensated cirrhosis). Compensated cirrhosis is defined as cirrhosis with Child Pugh score = A(5-6)

□ Detectable levels of HCV/ RNA value within the last 6 months and a copy of the quantitative HCV RNA report is attached.

□ Fibrosis stage F2 or greater (Metavir scale or equivalent) – Based on:

- □ Transient Elastography (kPa)________(attach copy of report)
- □ Liver biopsy confirmed (attach copy of report)

If treatment experienced, past therapies/outcomes include:____

Drug and Duration of Therapy

□ Harvoni®(ledipasvir and sofosbuvir)

8 weeks (Coverage is for a maximum of 8 weeks. No renewals)

□ Treatment-naive, non-cirrhotic, viral load < 6 M IU/mL

12 weeks (Coverage is for a maximum of 12 weeks. No renewals)

□ Treatment-naive, non-cirrhotic, viral load > 6 M IU/mL
□ Treatment-naive cirrhotic
□ Treatment-experienced, non-cirrhotic

24 weeks (Coverage is for a maximum of 24 weeks. No renewals)

□ Treatment-experienced, cirrhotic

□ Sovaldi® (sofosbuvir) **□ Ibavyr® (ribavirin)**

12 weeks (Coverage is for a maximum of 12 weeks. No renewals)

For Genotype 1 in combination with Peg IFN/RBV

□ Treatment-naive patients

For Genotype 2 in combination with ribavirin (Ibavyr®)

□ Treatment-naive patients in whom interferon is medically contraindicated.
Contraindication:__________________________________
□ PegIFN/RBV treatment-experienced patients

24 weeks (Coverage is for a maximum of 24 weeks. No renewals)

For Genotype 3 in combination with ribavirin (Ibavyr®)

□ Treatment-naive patients in whom interferon is medically contraindicated.
Contraindication:__________________________________
□ PegIFN/RBV treatment-experienced patients

Other comments:

Prescriber:	□ Gastroenterologist	□ Infectious **Disease Specialist**	**□Other physician experienced in treating chronic Hepatitis C**

Prescriber Name:
(please print) License Number:

Address: Phone Number: Fax Number:

Signature: Date:

Please note that Special Authorization Requests normally take approximately 10 working days to be processed.

Version June 2015 – Replaces previous forms