SPECIAL AUTHORIZATION REQUEST FORM
The Newfoundland and Labrador Prescription Drug Program (NLPDP)
Request for Coverage Hepatitis C Treatments

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

☐ **Lab confirmed Hepatitis C, Genotype(s):** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

Fibrosis Score: Date (mm/dd/yyyy) Method Used:

Hepatits C virus RNA Value: (IU/mL) Date (mmddyyyy)

Cirrhosis: ☐Yes ☐No If yes, provide: Child-Turcotte Score (CTP): ☐ A(5-6) ☐ B(7-9) ☐ C(10-15)

Please indicate all of the following that apply to this patient:

- ☐ Co-infected with HIV or Hepatitis B
- ☐ Post organ transplant (liver or non-liver)
- ☐ Extrahepatic manifestations
- ☐ Woman of childbearing age who is planning a pregnancy within the next 12 months
- ☐ Chronic Kidney Disease stage 3, 4 or 5 as defined in the National Kidney Foundation Kidney Disease Outcomes Quality Initiative
- ☐ Co-existent liver disease with diagnostic evidence of fatty liver disease (e.g. non-alcoholic steatohepatitis)
- ☐ Patients with diabetes being treated with antihyperglycemic medications

Drug(s) and Duration of Therapy

Drug	Duration (weeks)	Drug	Duration (weeks)	Regimen
Sofosbuvir/Velpatasvir **(Epclusa)**	☐ 12	Sofosbuvir **(Sovaldi)**	☐ 12 ☐ 24	**In combination with ribavirin?**
Daclatasvir **(Daklinza)**	☐ 12 ☐ 24	Asunaprevir **(Sunvepra)**	☐ 12	**☐ Yes ☐ No**
Sofosbuvir/Ledipasvir **(Harvoni)**	☐ 8 ☐ 12 ☐ 24	Elbasvir/Grazoprevir **(Zepatier)**	☐ 8 ☐ 12 ☐ 18	**Dose:**

Previous Hepatitis C Therapies

Drug(s)	Start date(s)	End dates(s)	Response to treatment(s)
			☐ Intolerance ☐ Lack of efficacy (e.g. null responder, partial responder, on-treatment virologic failure, relapse, etc.) Describe:
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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 October 2017 – Replaces previous forms