# PRIOR AUTHORIZATION REQUEST FORM

**EOC ID:**

# Daklinza (daclatasvir)

**Phone: 800-728-7947 Fax back to: 866-880-4532**

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

| **Patient Name:** | **Prescriber Name:**<br>**Supervising Physician:** | |
|---|---|---|
| Member/Subscriber Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Group Number: | NPI: | State Lic ID: |
| Address: | Address: | |
| City, State ZIP: | City, State ZIP: | |
| Primary Phone: | Specialty/facility name (if applicable): | |

Drug Name and Strength:

Directions / SIG:

**Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.**

Q1. What is the requested regimen and duration of therapy?

- ☐ Daklinza 30 mg once daily PLUS Sovaldi x 12 weeks
- ☐ Daklinza 60 mg once daily PLUS Sovaldi x 12 weeks
- ☐ Daklinza 90 mg once daily PLUS Sovaldi x 12 weeks
- ☐ Other

Q2. Specify the prescriber's specialty.

- ☐ Hepatologist
- ☐ Board Certified Infectious Disease specialist
- ☐ Board Certified Gastroenterologist
- ☐ Other (please specify)

Q3. Is the patient greater than or equal to 18 years of age?

☐ Yes ☐ No

Q4. What is the patient's diagnosis?

- ☐ Genotype 1a chronic HCV
- ☐ Genotype 1b chornic HCV
- ☐ Genotype 2 chronic HCV
- ☐ Genotype 3 chronic HCV

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☐ Genotype 4 chronic HCV
☐ Other (please specify)

Q5. Please provide ICD code(s) for diagnosis

Q6. What is the patient's Metavir score?

☐ Metavir Score F0
☐ Metavir Score F1
☐ Metavir Score F2
☐ Metavir Score F3 (Advanced Fibrosis)
☐ Metavir Score F4 (Cirrhosis)
☐ Other (Please Specify)
☐ Unknown

Q7. How was the patient's Metavir score confirmed? [NOTE: Examples of non-invasive tests include: APRI, FIB-4, FibroIndex, Forns Index, HepaScore/FibroScore, FibroSure, cirrhosis on imaging, ShearWave Elastography, FibroScan, magnetic resonance elastography]

☐ Liver biopsy
☐ TWO non-invasive tests
☐ None of the above

Q8. I have provided documentation of the liver biopsy or results of TWO non-invasive tests used to determine patient's fibrosis score.

☐ Yes ☐ No

Q9. Select any of the diagnoses below that apply to this patient:

☐ Cryoglobulinemia AND either vasculitis, peripheral neuropathy, OR Reynaud's phenomenon
☐ Membranoproliferative glomerulonephritis
☐ Membranous nephropathy
☐ None of the above

Q10. Has the patient had a liver transplant?

☐ Yes ☐ No

Q11. Does the patient have hepatocellular carcinoma (HCC) meeting MILAN criteria, AND is the patient on the liver transplant list?

☐ Yes ☐ No

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Q12. Provide MELD score, blood type, and duration of time that patient has been on the transplant list.

Q13. Will Daklinza be used concomitantly with sofosbuvir?

☐ Yes ☐ No

Q14. Has the patient been abstinent from alcohol and IV drug use for the previous 6 months?

☐ Yes ☐ No

Q15. Is patient interferon-ineligible? [Defined as a DOCUMENTED history of at least ONE of the conditions below]

☐ Yes ☐ No

Q16. If you answered "yes" to the question above: which of the following DOCUMENTED conditions apply?

- ☐ Autoimmune hepatitis
- ☐ Known hypersensitivity reactions (urticaria, angioedema, bronchoconstriction, anaphylaxis)
- ☐ Steven Johnson syndrome, sarcoidosis, or other serious skin reaction
- ☐ Diagnosed psychiatric disorder (major depressive disorder, aggressive behaviors, psychoses, hallucinations, bipolar disorder or manic episodes, suicidal attempts)
- ☐ Prior history of psychiatric disturbances on interferon therapy
- ☐ Uncontrolled hypertension, arrhythmia or coronary artery disease despite treatment
- ☐ Baseline neutrophil count <1,500 cells/mm3
- ☐ Baseline platelet count <90,000 cells/mm3 (<75,000 if cirrhotic, <70,000 if HIV co-infected)
- ☐ Baseline hemoglobin <10 g/dL
- ☐ Serum creatinine >1.5 x ULN
- ☐ Uncontrolled thyroid abnormalities; TSH and T4 outside normal limits despite treatment
- ☐ CD4 count <200 cells/mm3 (<100 cells/mm3 if HIV co-infected)
- ☐ Uncontrolled diabetes mellitus despite treatment

Q17. Select any of the following that apply to this patient.

- ☐ Compensated cirrhosis
- ☐ Decompensated cirrhosis
- ☐ Concurrent use of drugs that are strong inducers of CYP3A (e.g. phenytoin, carbamazepine, rifampin, St. John's wort)
- ☐ Any other non-liver related comorbidity resulting in less than a 10-year predicted survival
- ☐ Ongoing non-adherence to prior medications or medical treatment
- ☐ Failure to complete HCV disease evaluation, appointments and procedures (e.g. laboratories)
- ☐ Presence of NS5A polymorphisms at amino acid positions M28, Q30, L31, and Y93

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☐ None of the above

Q18. Select the agents that the patient has been treated with previously:

- ☐ Treatment naive
- ☐ Peginterferon & Ribavirin (Dual Therapy)
- ☐ Elbasvir (Zepatier)
- ☐ Dasabuvir (Viekira)
- ☐ Grazoprevir (Zepatier)
- ☐ Ledipasvir (Harvoni)
- ☐ Ombitasvir (Viekira; Technivie)
- ☐ Paritaprevir (Viekira; Technivie)
- ☐ Simeprevir (Olysio)
- ☐ Sofosbuvir (Sovaldi or Harvoni)
- ☐ None of the above

Q19. If requesting a dose adjustment (Daklinza 30 mg or 90 mg daily) due to a drug-drug interaction: Is the interacting drug medically necessary and cannot be avoided during the three months of hepatitis C treatment?

☐ Yes ☐ No

Q20. Additional Comments

Prescriber Signature _____ Date _____

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been

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decided.