

**Direct-Acting Antiviral (DAA) Agents Used to Treat Chronic Hepatitis C Virus (HCV)
Medication Therapy Worksheet for Louisiana Medicaid Recipients**

Note: This worksheet must be completed in full and submitted with supporting documentation where applicable. [See DAA Clinical Authorization Criteria]

Recipient Name:	Medicaid Recipient ID #:	Recipient DOB:	Recipient weight:
Prescriber Name:	Prescriber Specialty:	Medicaid Provider ID #:	Office Contact:

Medication regimen requested [Choose one.]

- | | |
|-----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Daclatasvir (Daklinza™) | <input type="checkbox"/> Daclatasvir / Sofosbuvir (Daklinza™/ Sovaldi®) |
| <input type="checkbox"/> Elbasvir / Grazoprevir (Zepatier®) | <input type="checkbox"/> Glecaprevir / Pibrentasvir (Mavyret™) |
| <input type="checkbox"/> Ledipasvir / Sofosbuvir (Harvoni®) | <input type="checkbox"/> Ombitasvir / Paritaprevir / Ritonavir with Dasabuvir (Viekira Pak™) |
| <input type="checkbox"/> Ledipasvir / Sofosbuvir (Authorized Generic (AG) of Harvoni®) | <input type="checkbox"/> Sofosbuvir / Velpatasvir (Epclusa®) |
| <input type="checkbox"/> Sofosbuvir (Sovaldi®) | <input type="checkbox"/> Sofosbuvir / Velpatasvir / Voxilaprevir (Vosevi™) |
| <input type="checkbox"/> Sofosbuvir / Velpatasvir (Authorized Generic (AG) of Epclusa®) | |

[This form is not necessary because Epclusa® AG is preferred and does not require authorization.]

Duration of therapy requested: ____ weeks <i>[If duration is greater than minimum duration stated per prescribing information, please provide rationale below for extended duration.]</i>
Reason for extended duration request (if applicable):
Does patient have a diagnosis of Chronic Hepatitis C (HCV)? <input type="checkbox"/> Yes <input type="checkbox"/> No Please specify genotype:
Is patient treatment-naïve? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide previous HCV therapy:
Was previous therapy completed? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide reason for discontinuation.
Has the patient experienced treatment failure with the preferred product? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has the patient had an intolerable side effect with the preferred product? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain in detail:
Does the patient have documented contraindication(s) to the preferred product? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain in detail:
If there is no preferred product that is appropriate to use for the condition being treated, please explain in detail:

By signing below, the prescriber attests that the information provided herein is true and accurate to the best of his/her knowledge. Also, by signing and submitting this request form, the prescriber attests to statements in the ‘Attestation’ section of the criteria specific to this request.

Physician Signature:* _____ **Date:** _____

**(Signature stamps and proxy signatures are not acceptable.)*

CONFIDENTIAL NOTICE

The documents accompanying this facsimile transmission may contain confidential information which is legally privileged. The information is intended only for the use of the individual or entity to which it is addressed. If you are not the intended recipient you are hereby notified that any review, disclosure/re-disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy this information.