reliance|rx℠
45 Earhart Drive, Suite 110, Amherst, NY 14221

HEPATITIS C AUTHORIZATION AND RE-AUTHORIZATION

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Member Name	Today's Date	Date Needed	
Date of birth: Sex: Weight:		Prescriber	Hospital/Clinic
Home Phone Number ( )		Phone Number ( )	Fax Number ( )
Home Address City State Zip		Address	City State Zip
Member's Insurance ID:		Office Phone #:	Office Fax Number:
Allergies:		Office Contact:	

DRUG SELECTION AND STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: _____
ICD10 Code: _____ Genotype: _____
Estimated Length of Therapy: _____HCV RNA: _____On Date: _____ALT: _____
AST: _____

If ALT is WNL:

- Submit liver biopsy results_____
- Is this patient motivated to complete treatment and have you discussed the risks vs. benefits and adverse effects of therapy with the patient or the patient's guardian?
  ☐Yes ☐No

Fibrosure test score_____

APRI score: _____

Is patient naive to therapy? ☐Yes ☐No

If no, please provide details of previous treatment including medication, dosage, dates of treatment and baseline, and 4 and 12 week HCV RNA lab values for this prior treatment: _____

_____

Please include a list of failed therapy:

_____
_____
_____

Do any of these apply (check all that apply)?

☐Female patient who is pregnant
☐Male patient whose female partner is pregnant
☐Patient has autoimmune hepatitis
☐Patient has decompensated liver disease
☐Patient has hemoglobinopathies (e.g., thalassemia major, sickle cell anemia)
☐Alcohol or drug use in past 6 months
☐Patient is co-infected with HIV
☐Psychiatric disorder
☐Has this patient been compliant with HCV disease evaluation, appointments, procedures, and medication regimen
☐Yes ☐No

Additional information requested:

Drug Name **Dose and Frequency**

☐Daklinza _____

☐Epclusa _____

☐Harvoni _____

☐Olysio _____

Please check all that apply if yes:
☐Co-infected with Hepatitis B
☐Sulfa allergy
☐History of liver transplant
☐Decompensated liver disease
☐Severe hepatic impairment (Child Pugh Class C)

☐Ribavirin _____

Please check all that apply if yes:
☐History of thyroid disorders
☐Has Diabetes Mellitus
☐History of Cardiovascular disease
☐CrCl < 50 ml/min

Confirmed patient will use at least 2 effective methods of contraception during treatment, and monthly pregnancy tests during, and 6 months after treatment ☐Yes ☐No

☐Sovaldi _____

Please check all that apply if yes:
☐Patient life expectancy > 12 months
☐Have baseline neutrophil count
☐List SCr:_____ and weight(lbs)_____
Patient verbally or in writing commits to documented planned course of treatment (anticipated blood tests and visits) ☐Yes ☐No

☐Technivie _____

☐List GFR_____

☐Viekira _____

☐Viekira XR _____

Please submit documentation of the following:
☐Patient is without decompensated cirrhosis
☐Patient does not have hepatocellular carcinoma

☐Zepatier _____

☐Other _____