KAISER PERMANENTE®

Kaiser Permanente Washington Specialty Pharmacy (KPWASP)
Hepatitis C Enrollment Form for all PROVIDERS
Phone: 1-800-483-3945 or (206) 630-7940
Fax Referral To: 1-800-340-4230 or (206) 630-7941

Instructions: Please complete form, attach required documentation, and fax to 1-800-340-4230 or 206-630-7941

Documentation Required:

1. Most recent HCV related chart note, current medication list, and stage of fibrosis (lab or diagnostic test result).
2. Lab work:
   - HCV genotype, HCV RNA quantitative (2 results ≥ 6 months apart with the most recent within prior 90 days)
   - **Result within prior 90 days:** CBC with differential, albumin, bilirubin, ALT, AST, creatinine, INR
   - **Result within prior 6 months:** Hepatitis B core antibody and Hepatitis B surface antigen

1 PATIENT INFORMATION

Patient Name: ____________________

Phone: ____________________

MRN #: ____________ DOB: ____________

2 PRESCRIBER INFORMATION

Prescriber's Name: ____________________

Clinic Name/Location: ____________________

Phone: ____________ Fax: ____________

3 CLINICAL INFORMATION

Diagnosis (ICD-10 code): □ B18.2 Chronic Viral Hepatitis C

Patient had a detectable viral load ≥ 6 months after initial detection of HCV RNA**?** □ **Yes*** □ No

***Requires verification: Include 2 HCV RNA quantitative results at least 6 months apart**

Patient's HCV Genotype: □ 1a □ 1b □ 1 □ 2 □ 3 □ 4 □ 5 □ 6

Fibrosis score (Metavir): □ F0 □ F1 □ F2 □ F3 □ F4

FOR Patients with Cirrhosis: □ compensated □ decompensated: CTP score: □ B (7-9) □ C (10-15)

Fibrosis score determined by (check all that apply) : □ APRI □ ARFI □ Biopsy □ FibroScan □ FibroSURE □ N/A, Clinical Cirrhosis

Treatment Status: □ Treatment Naïve □ Partial Responder □ Null Responder □ Relapser

Prior Treatment:

Regimen: ____________________ Length of treatment: ____________

If treatment stopped early, reason for stopping: ____________________

Check all that apply:

□ hepatic carcinoma
□ awaiting liver transplant
□ unstable cardiac disease
□ **eGFR or CrCl < 30 mL/min**
□ **Human Immunodeficiency Virus (HIV)**
□ **post-transplant (liver, kidney, heart)**
□ history of major/uncontrolled depression
□ membranoproliferative glomerulonephritis
□ **Hepatitis B (HBV)**
□ hemoglobinopathy
□ cryoglobulinemia

Allergies:

Patient's Weight: ____________ □ lbs □ kg **Date:** ________

Current Medication List: ***Please attach current medication list to allow for drug interaction review.***

Patient Education/ Commitment:

Provider attests that patient has been educated regarding antiviral therapy, risk factors for fibrosis progression, and the importance of adherence to treatment. □ **Yes** □ **No**

Provider attests that he/she is confident in the patient's ability to maintain medication adherence. □ **Yes** □ **No**

Hep B Testing

Screening for hepatitis B infection is required within 6 months of starting hepatitis C treatment.

Hepatitis B core antibody: □ Non-reactive □ Reactive

Hepatitis B surface antigen: □ Non-reactive or Negative □ Reactive or Positive

I attest my patient is clear to begin HCV treatment. In the case where my patient is currently or previously co-infected with Hep B, additional testing will occur during and after treatment to monitor for any untoward flare or reactivation of Hep B virus.

□ **Yes** □ **No**

The submitting provider certifies that the information **provided** *is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient:*

____________________ ____________

Prescriber's Signature Date

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4 PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
□ velpatasvir/ sofosbuvir* (EPCLUSA) **Preferred*	100mg/ 400mg tablets	Take 1 tablet (100mg velpatasvir/ 400mg sofosbuvir) orally once a day.	28 day supply	2 refills
□ voxilaprevir/ velpatasvir/ sofosbuvir (VOSEVI)	100mg/ 100mg/ 400mg tablets	Take 1 tablet by mouth once a day WITH FOOD	28 day supply	2 refills
□ glecaprevir/ pibrentasvir (MAVYRET)	100mg/ 40mg tablets	Take 3 tablets (300mg glecaprevir/ 120mg pibrentasvir) by mouth once a day WITH FOOD.	28 day supply	___ refill(s)
□ ribavirin	200 mg capsules or tablets (Pharmacy to select dosage form based on supply and indication)	Directions: ____	28 day supply	2 refills
□ Other			28 day supply	2 refills

Length of Therapy: □ 8 weeks □ 12 weeks □ 16 weeks □ 24 weeks □ Other _____ weeks

Starting Treatment: (Please select preference)

□ Patient to start treatment upon receipt of medication
□ Ship medication to patient. Patient to contact office prior to starting treatment.
□ Ship medication to provider office. Office to determine start date.
□ Other:

Patient is interested in patient financial assistance programs □ Yes □ No

5 PHYSICIAN SIGNATURE REQUIRED

X ____ SUBSTITUTION PERMITTED (Date)

X ____ DISPENSE AS WRITTEN (Date)

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