CVS CAREMARK

Fax Referral To: 800-323-2445
Phone: 866-278-6634

Hepatitis C
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION (*Please copy and attach the front and back of insurance and prescription drug card)*

Prescription Card: Name of Insurer: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____
Primary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI** Phone: _____
Secondary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 code): ☐ 070.54 Hepatitis C (Chronic) ☐ Other: _____ • Date of Diagnosis: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

FOR ALL HEPATITIS C THERAPY REQUESTS:

- What is the patient's age? _____ (years)
- Hepatitis C virus (HCV) Genotype: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6
- Is patient: ☐Treatment naïve ☐Partial responder ☐Null responder ☐Relapser
  Partial responder = HCV RNA decreased by ≥ 2-$\log_{10}$ by week 12 but was not undetectable at end of treatment
  Null responder = HCV RNA decreased by < 2-$\log_{10}$ by week 12 of treatment
  Relapser = HCV RNA was undetectable at end of treatment but was detectable during follow-up
- Previous hepatitis C regimen:_____
- Is patient currently on hepatitis C therapy? ☐Yes ☐No • Current regimen_____
- Patient has confirmed hepatitis C with compensated liver disease ☐ Yes ☐ No
- At baseline, patient has detectable HCV RNA ☐ Yes ☐ No
- Is patient taking ribavirin? ☐ Yes ☐ No If no, does patient have a contraindication to ribavirin? ☐ Yes ☐ No
- Does the patient have cirrhosis? ☐ Yes ☐ No
- Does the patient have renal failure? ☐ Yes ☐ No

FOR PEGYLATED INTERFERON + RIBAVIRIN + HCV PROTEASE INHIBITOR (TRIPLE THERAPY) REQUESTS:

- Is the HCV protease inhibitor prescribed by, or in consultation with, a gastroenterologist, hepatologist or infectious disease specialist? ☐ Yes ☐ No
- Is the patient co-infected with human immunodeficiency virus (HIV), hepatitis B, or is an organ transplant recipient? ☐ Yes ☐ No
- Is the patient naïve to HCV protease inhibitor therapy? ☐ Yes ☐ No
- Will the HCV protease inhibitor be given in combination with pegylated interferon and ribavirin? ☐ Yes ☐ No
- Will the patient receive 4 weeks of pegylated interferon and ribavirin before starting Victrelis? ☐ Yes ☐ No ☐ Not applicable
- Will the HCV protease inhibitor be given in combination with any of the drugs listed below? ☐ Yes ☐ No
  - Tadalafil or sildenafil (Adcirca or Revatio for pulmonary hypertension) • Alfuzosin • Atorvastatin, lovastatin, or simvastatin • Ergot derivatives • Oral midazolam or triazolam
  - Pimozide • Rifampin • Phenytoin, carbamazepine, or phenobarbital • St. John's wort • Drospirenone (oral contraceptive)
- Will a sensitive real-time RT-PCR assay be used for monitoring HCV RNA levels (quantitative limit of detection [LOD] ≤25 IU/mL or qualitative LOD 10-15 IU/mL)? ☐ Yes ☐ No
- Will HCV RNA levels be measured at weeks 4, 12, and 24 of treatment (and week 8 if taking Victrelis)? ☐ Yes ☐ No *****HCV RNA levels (below) are required for continuation of therapy*****
- Week 4 HCV RNA level: ☐ Undetectable ☐ <100 IU/mL ☐ ≤1000 IU/mL ☐ Other _____
- Week 8 HCV RNA level: ☐ Undetectable ☐ <100 IU/mL ☐ ≤1000 IU/mL ☐ Other _____
- Week 12 HCV RNA level: ☐ Undetectable ☐ <100 IU/mL ☐ ≤1000 IU/mL ☐ Other _____
- Week 24 HCV RNA level: ☐ Undetectable ☐ <100 IU/mL ☐ ≤1000 IU/mL ☐ Other _____
- Was there a less than 1.0-$\log_{10}$ decline in HCV RNA at week 4 of treatment? ☐ Yes ☐ No

FOR INTERFERON + RIBAVIRIN (DUAL THERAPY) OR INTERFERON MONOTHERAPY REQUESTS:

- Liver biopsy (unless contraindicated) shows fibrosis and inflammation or necrosis ☐ Yes ☐ No
- Does the patient have detectable HCV RNA after 12 weeks of therapy? ☐ Yes ☐ No
- Did the patient have a decrease in HCV RNA > 2-$\log_{10}$ (i.e., from 1,200,000 to 12,000) from baseline after 12 weeks of therapy? ☐ Yes ☐ No

CONTINUED ON PAGE 2

PRESCRIPTION INFORMATION

PEGASYS® ☐ 180ug/0.5ml Prefilled Syringe ☐ 180ug/1ml Vial

Directions: ☐ Inject 180ug subcutaneously once a week as directed

☐ Other: _____

Quantity: _____ Refills: _____

PEGINTRON® ☐ Redipen® ☐ Vial

PegIntron™ dosing based on 1.5ug/kg week in combination with Ribavirin

Weight	Redipen®/Vial Strength or Size	Directions
☐<88lbs	50/0.5	Inject 0.5ml subcutaneously once a week.
☐89-110lbs	80/0.5	Inject 0.4ml subcutaneously once a week.
☐111-132lbs	80/0.5	Inject 0.5ml subcutaneously once a week.
☐133-165lbs	120/0.5	Inject 0.4ml subcutaneously once a week.
☐166-187lbs	120/0.5	Inject 0.5ml subcutaneously once a week.
☐>187lbs	150/0.5	Inject 0.5ml subcutaneously once a week.

☐Other: _____

Quantity: _____ Refills: _____

RIBA-PAK® (generic ribavirin) tablet dose pack

Directions: ☐ Take 600mg tab po qam and 600mg tab po qpm =1200/day (600-600)

☐ Take 600mg tab po qam and 400mg tab po qpm =1000/day (600-400)

☐ Take 400mg tab po qam and 400mg tab po qpm =800/day (400-400)

Quantity: _____ Refills: _____

RIBASPHERE® ☐ 200mg tablets ☐ 200mg capsules

Directions: Take _____ tabs/caps po qam and _____ tabs/caps po qpm.

Quantity: _____ Refills: _____

INCIVEK™ (telaprevir) ☐ 375 mg tabs

Directions: Oral – 750 mg (2 tabs of 375 mg each) take orally three times daily every 7-9 hours with food. Take in week 1 through 12 of pegylated interferon therapy.

Quantity: 28 day supply Refills: _____

VICTRELIS™ (boceprevir) ☐ 200 mg caps

Directions: Oral - 800mg (4 caps of 200 mg each) take orally three times daily (every 7-9 hours) with food. Begin after week 4 of Pegylated interferon therapy

Quantity: 28 day supply Refills: _____

OTHER MEDICATIONS ☐ _____

Directions: _____

Quantity: _____ Refills: _____

INFERGEN® ☐ 15ug/0.5ml vial ☐ 9ug/0.3ml vial

Direction ☐ Inject 15ug sc three times a week. ☐ Inject 9ug sc three times a week.

Quantity: _____ Refills: _____

Ancillary Supplies and Kits Provided As Needed for Administration

X _____

PRODUCT SUBSTITUTION PERMITTED (Date)

X _____

DISPENSE AS WRITTEN (Date)