



SPECIAL AUTHORIZATION REQUEST FORM
The Newfoundland and Labrador Prescription Drug Program (NLPDP)
Request for Coverage Hepatitis C Treatments

Pharmaceutical Services
 Department of Health and Community Services
 P.O. Box 8700, Confederation Bldg.
 St. John's, NL A1B 4J6

Phone: (709) 729-6507
 Toll Free Line: 1-888-222-0533
 Fax: (709) 729-2851

Patient Information

Patient Name	Date of Birth	NLPDP Drug Card/MCP Number
Address		

Diagnostic Information

Treatment Naïve: Yes No

For Treatment Experienced patients, please complete genotype (genotype must be from post-treatment course.)

Lab confirmed Hepatitis C, Genotype(s): 1 2 3 4 5 6

Please provide confirmation of TWO consecutive positive HCV RNA results, at least 6 months apart:

1: HCV RNA value: _____ (IU/ml) Date: _____ **OR** HCV RNA Detected on Date: _____

2: HCV RNA value: _____ (IU/ml) Date: _____ **OR** HCV RNA Detected on Date: _____

Cirrhosis: Yes No If yes provide: Child-Turcotte Score (CTP): A(5-6) B (7-9) C (10-15)

Requested Drug(s) and Duration of Therapy

Drug	Duration (weeks)	Drug	Duration (weeks)
Sofosbuvir/Velpatasvir (Epclusa)	<input type="checkbox"/> 12	Sofosbuvir (Sovaldi)	<input type="checkbox"/> 12 <input type="checkbox"/> 24
Sofosbuvir/Velpatasvir/Voxilaprevir (Vosevi)	<input type="checkbox"/> 12	Glecaprevir/Pibentasvir (Maviret)	<input type="checkbox"/> 8 <input type="checkbox"/> 12 <input type="checkbox"/> 16
Sofosbuvir/Ledipasvir (Harvoni)	<input type="checkbox"/> 8 <input type="checkbox"/> 12 <input type="checkbox"/> 24		

Previous Hepatitis C Therapies

Drug(s)	Start date	End date	Response to treatment(s)
			<input type="checkbox"/> Intolerance <input type="checkbox"/> Lack of efficacy (e.g. null responder, partial responder, on-treatment virologic failure, relapse, etc.) Describe:
			<input type="checkbox"/> Intolerance <input type="checkbox"/> Lack of efficacy (e.g. null responder, partial responder, on-treatment virologic failure, relapse, etc.) Describe:

Prescriber: **Gastroenterologist** **Infectious Disease Specialist** **Other physician experienced in treating chronic Hepatitis C**

Prescriber Name: _____ License Number: _____
 (please print)

Address: _____ Phone Number: _____ Fax Number: _____

Signature: _____ Date: _____