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 positive HCV RNA result within 12 months of this request:

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

Please provide the anticipated start date:
□ Immediately (today) □ Start 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)**	□ 12	Sofosbuvir **(Sovaldi)**	□ 12 □ 24
Sofosbuvir/Velpatasvir/Voxilaprevir **(Vosevi)**	□ 12	**Glecaprevir/Pibentasvir (Maviret)**	**□ 8 □ 12 □ 16**
Sofosbuvir/Ledipasvir **(Harvoni)**	□ 8 □ 12 □ 24		

Previous Hepatitis C Therapies

Drug(s)	Start date	End date	Response to treatment(s)
			□ Intolerance □ Lack of efficacy (e.g. null responder, partial responder, on-treatment virologic failure, relapse, etc.) Describe:_____
			□ Intolerance □ Lack of efficacy (e.g. null responder, partial responder, on-treatment virologic failure, relapse, etc.) Describe:_____

Prescriber Information/Requested: ☐ Physician ☐ Nurse Practitioner
Prescriber Name: _____ License Number: _____Phone Number_____
Address: _____ Fax Number:_____
Signature: _____Date:_____
Pharmacist Name:
(optional)_____Pharmacy:_____
Signature:_____Date:_____