



**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**

<b>Patient Name</b>	<b>Date of Birth</b>	<b>NLPDP Drug Card/MCP Number</b>
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**Address**

**Diagnostic Information**

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

Hepatitis C virus RNA value: \_\_\_\_\_ (IU/ml) Date: \_\_\_\_\_

Fibrosis Score: \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_\_\_ Method: \_\_\_\_\_

Please provide genotype report, HCV RNA report and report confirming fibrosis stage. For treatment experienced patients, genotype must be from post-treatment course.

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**

<b>Drug</b>	<b>Duration (weeks)</b>	<b>Drug</b>	<b>Duration (weeks)</b>	<b>Regimen</b>
Sofosbuvir/Velpatasvir ( <b>Epclusa</b> )	<input type="checkbox"/> 12	Sofosbuvir ( <b>Sovaldi</b> )	<input type="checkbox"/> 12 <input type="checkbox"/> 24	<b>In combination with ribavirin?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Dose:</b> _____
Sofosbuvir/Velpatasvir/Voxilaprevir ( <b>Vosevi</b> )	<input type="checkbox"/> 12	Asunaprevir ( <b>Sunvepra</b> )	<input type="checkbox"/> 12	
Sofosbuvir/Ledipasvir ( <b>Harvoni</b> )	<input type="checkbox"/> 8 <input type="checkbox"/> 12 <input type="checkbox"/> 24	Elbasvir/Grazoprevir ( <b>Zepatier</b> )	<input type="checkbox"/> 8 <input type="checkbox"/> 12 <input type="checkbox"/> 18	
Glecaprevir/Pibentasvir ( <b>Maviret</b> )	<input type="checkbox"/> 8 <input type="checkbox"/> 12 <input type="checkbox"/> 16			

**Previous Hepatitis C Therapies**

<b>Drug(s)</b>	<b>Start date</b>	<b>End date</b>	<b>Response to treatment(s)</b>
			<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:  
(please print)

License Number:

Address:

Phone Number:

Fax Number:

Signature:

Date:

Please note that Special Authorization Requests normally take approximately 10 working days to be processed.

**Version January 2020 – Replaces previous for**