BRITISH COLUMBIA | Ministry of Health

SPECIAL AUTHORITY REQUEST

SOFOSBUVIR PLUS RIBAVIRIN WITH OR WITHOUT PEGINTERFERON FOR CHRONIC HEPATITIS C

HLTH 5399 Rev. 2016/10/20

For up to date criteria and forms, please check: www.gov.bc.ca/pharmacarespecialauthority

Fax requests to 1 800 609-4884 (toll free) OR mail requests to: PharmaCare, Box 9652 Stn Prov Govt, Victoria, BC V8W 9P4

This facsimile is Doctor-Patient privileged and contains confidential information intended only for PharmaCare. Any other distribution, copying or disclosure is strictly prohibited. If you have received this fax in error, please write "MIS-DIRECTED" across the front of the form and fax toll-free to 1 800 609-4884, then destroy the pages received in error.

If PharmaCare approves this Special Authority request, approval is granted solely for the purpose of covering prescription costs. PharmaCare approval does not indicate that the requested medication is, or is not, suitable for any specific patient or condition.

Forms with information missing will be returned for completion. If no prescriber fax or mailing address is provided, PharmaCare will be unable to return a response.

Restricted to:

☐ **Gastroenterologist** ☐ **Infectious Disease Specialist** ☐ **Other physician experienced with treating chronic Hepatitis C**

SECTION 1 – PRESCRIBER INFORMATION

NAME AND MAILING ADDRESS ☐ MAIL CONFIRMATION

☐ COLLEGE ID **OR** ☐ MSP NUMBER

PHONE NUMBER (INCLUDE AREA CODE)

CRITICAL FOR A TIMELY RESPONSE →

PRESCRIBER'S FAX NUMBER

SECTION 2 – PATIENT INFORMATION

PATIENT (FAMILY) NAME

PATIENT (GIVEN) NAME(S)

DATE OF BIRTH (YYYY / MM / DD)

DATE OF APPLICATION (YYYY / MM / DD)

CRITICAL FOR PROCESSING →

PERSONAL HEALTH NUMBER (PHN)

SECTION 3 – BACKGROUND DIAGNOSTIC INFORMATION

For the treatment of patients with Chronic Hepatitis C genotype 1, 2, or 3 who meet all the following criteria:

☐ Patient has compensated liver disease (i.e. with no cirrhosis or with compensated cirrhosis). Compensated cirrhosis is defined as cirrhosis with a Child Pugh score = A (5-6).

☐ Genotype has been confirmed and a copy of the genotype report is attached.

☐ Detectable levels of hepatitis C virus (HCV RNA) in the last six months.

☐ A fibrosis stage F2 or greater (Metavir scale or equivalent) and values or confirmation provided below (complete ONE):

- ☐ Transient Elastography (kPa) _____
- ☐ APRI score _____
- ☐ FIB-4 score _____
- ☐ liver biopsy confirmed

Not eligible for coverage:

1. **Patients who are at high risk for non-compliance.**
2. **Patients who are currently being treated with another HCV antiviral agent.**
3. **Retreatment requests.**

PHARMACARE USE ONLY

STATUS	EFFECTIVE DATE (YYYY / MM / DD)	DURATION OF APPROVAL

SOFOSBUVIR PLUS RIBAVIRIN WITH OR WITHOUT PEGINTERFERON FOR CHRONIC HEPATITIS C

PATIENT NAME	PHN	DATE (YYYY / MM / DD)

SECTION 4

A: GENOTYPE 1 PATIENTS

☐ Sofosbuvir in combination with peginterferon / ribavirin (pegINF/RBV).

☐ Treatment-naive.

COVERAGE is for a maximum of 12 weeks. No renewals.

B: GENOTYPE 2 PATIENTS

☐ Sofosbuvir in combination with ribavirin (RBV)

☐ Genotype 2 treatment-naive and interferon (INF) is medically contraindicated.

Details of contraindication(s):

_____

☐ Genotype 2 pegINF/RBV treatment-experienced.

COVERAGE is for a maximum of 12 weeks. No renewals.

- Medical contraindication to IFN is defined as hypersensitivity to peginterferon or interferon alfa-2a or 2b, polyethylene glycol, or any component of the formulation resulting in discontinuation of therapy; or presence of significant clinical comorbidities which are deemed to have a high risk of worsening with IFN treatment.
- Treatment-experienced patients are patients who have previously been treated with pegINF/RBV and did NOT receive an adequate response.

C: GENOTYPE 3 PATIENTS

☐ Sofosbuvir in combination with ribavirin (RBV)

☐ Genotype 3 treatment-naive and interferon (INF) is medically contraindicated.

Details of contraindication(s):

_____

☐ Genotype 3 pegINF/RBV treatment-experienced.

COVERAGE is for a maximum of 24 weeks. No renewals.

- Medical contraindication to IFN is defined as hypersensitivity to peginterferon or interferon alfa-2a or 2b, polyethylene glycol, or any component of the formulation resulting in discontinuation of therapy; or presence of significant clinical comorbidities which are deemed to have a high risk of worsening with IFN treatment.
- Treatment-experienced patients are patients who have previously been treated with pegINF/RBV and did NOT receive an adequate response.

SECTION 5: ADDITIONAL COMMENTS

Personal information on this form is collected, used and disclosed under the authority of, and in accordance with, the *British Columbia Pharmaceutical Services Act* and *Freedom of Information and Protection of Privacy Act*. It will not be disclosed to any persons without the patient's consent.The information you provide will be relevant to and used solely to (a) provide PharmaCare benefits for the medication requested, (b) to implement, monitor and evaluate this and other Ministry programs, and (c) to manage and plan for the health system generally. If you have any questions about the collection or use of this information, call Health Insurance BC from Vancouver at 1-604-683-7151 or from elsewhere in BC toll free at 1-800-663-7100 and ask to consult a pharmacist concerning the Special Authority process.

I have discussed with the patient that the purpose of releasing their information to PharmaCare is to obtain Special Authority for prescription coverage and for the purposes set out here.

_____

Prescriber's Signature (Mandatory)

PharmaCare may request additional documentation to support this Special Authority request.
Actual reimbursement is subject to the rules of a patient's PharmaCare plan, including any annual deductible requirement, and to any other applicable PharmaCare pricing policy.

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CLEAR FORM