



SPECIAL AUTHORITY REQUEST
GLECAPREVIR PLUS PIBRENTASVIR FOR
PEDIATRIC PATIENTS WITH CHRONIC HEPATITIS C

HLTH 5831 2024/08/13

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 privileged and contains confidential information intended only for PharmaCare. Any other distribution, copying or disclosure is strictly prohibited.

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.

If you have received this fax in error, please write MISDIRECTED across the front of the form and fax toll-free to 1-800-609-4884, then destroy the pages received in error.

Restricted to:

- Gastroenterologist Infectious Disease Specialist Other prescriber experienced with treating chronic Hepatitis C

SECTION 1 - PRESCRIBER INFORMATION

Name and Mailing Address
College ID (use ONLY College ID 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

GLECAPREVIR + PIBRENTASVIR SACHET: 9901-0467

For the treatment of pediatric patients aged 3 to less than 12 years old AND weigh between 12 kg to less than 45 kg with Chronic Hepatitis C genotype 1, 2, 3, 4, 5 or 6 who meet all the following criteria:

- Detectable levels of hepatitis C virus (HCV RNA) in the last twelve months. A quantitative HCV RNA or dried blood spot report is attached.
Genotype report from the latest HCV post-treatment course is required for treatment experienced-patients. Genotype report is not required for treatment-naive patients.
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).
Stage of fibrosis has been evaluated within ONE year by one of the following methods:
Transient elastography (kPa)
APRI score
FIB-4 score
Liver biopsy confirmed
Copy of most recent bloodwork evaluated within one year (i.e. CBC,AST,ALT,bilirubin) and report confirming fibrosis stage (if applicable) is attached.

Not eligible for coverage:

- 1. Patients who are at high risk for non-compliance.
2. Patients who are currently being treated with another HCV direct-acting antiviral agent

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.

PHARMACARE USE ONLY

Table with 3 columns: STATUS, EFFECTIVE DATE (YYYY / MM / DD), DURATION OF APPROVAL

PATIENT NAME	PHN	DATE (YYYY / MM / DD)
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**SECTION 4: GLECAPREVIR + PIBRENTASVIR** *(Coverage listed is maximum length - no renewals on all listings.)*

(CHOOSE FROM OPTION A, B OR C)

**A. GENOTYPE 1:**

**8 weeks coverage**

Treatment-naive with no cirrhosis or with compensated cirrhosis <sup>2</sup>.

Treatment-experienced <sup>1</sup> with no cirrhosis.

**OR**

**12 weeks coverage**

Treatment-experienced<sup>1</sup> with compensated cirrhosis <sup>2</sup>.

**OR**

**B. GENOTYPE 2, 4, 5 or 6:**

**8 weeks coverage**

Treatment-naive with no cirrhosis or with compensated cirrhosis <sup>2</sup>.

Treatment-experienced <sup>1</sup> with no cirrhosis.

**OR**

**12 weeks coverage**

Treatment-experienced <sup>1</sup> with compensated cirrhosis <sup>2</sup>.

**OR**

**C. GENOTYPE 3:**

**8 weeks coverage**

Treatment-naive with no cirrhosis or with compensated cirrhosis <sup>2</sup>.

**OR**

**16 weeks coverage**

Treatment-experienced <sup>1</sup> with no cirrhosis or with compensated cirrhosis <sup>2</sup>.

**NOTES:**

1. Treatment-experienced is defined as a patient who has been previously treated with **interferon, peginterferon-ribavirin (PR), ribavirin (RBV), and/or sofosbuvir (SOF) (PR, SOF + PR, SOF + RBV), but no prior treatment experience with an HCV NS3/4A protease inhibitor or NS5A inhibitor**, and who has relapsed or not responded to treatment.
2. Compensated cirrhosis is defined as cirrhosis with a Child Pugh score = A (5-6).

**SECTION 5 – ADDITIONAL COMMENTS**

Personal information on this form is collected under the authority of, and in accordance with, the *British Columbia Pharmaceutical Services Act 22(1)* and *Freedom of Information and Protection of Privacy Act 26 (a),(c),(e)*. The information is being collected for the purposes of (a) administering the PharmaCare program, (b) analyzing, planning and evaluating the Special Authority and other Ministry programs and (c) to manage and plan for the health system generally. If you have any questions about the collection 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.

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 Prescriber's Signature (Mandatory)