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 Note: Includes reinfection following previous successful treatment (i.e undetected viral load following treatment)
☐ No Note: Includes previous lack of response/intolerance to previous treatment course.

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
OR TWO positive HCV RNA results ≥ 12 months ago; tests must have been completed within 6 months apart.

HCV RNA value:_____(IU/ml) Date:_____ **OR** HCV RNA Detected on Date: _____
HCV RNA value:_____(IU/ml) Date:_____ **OR** HCV RNA Detected on Date: _____
In cases of previous successful treatment, please provide date of undetectable HCV test:_____

Please provide the anticipated start date:
☐ Immediately (today) OR ☐ 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)** ☐ **Tablets** ☐ **Granules (pediatric only)**	☐ 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:_____ ☐ undetected viral load following previous treatment
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Prescriber Information/Requested: ☐ Physician ☐ Nurse Practitioner
Prescriber Name: _____ License Number: _____Phone Number_____
Address: _____ Fax Number:_____
Signature: _____Date:_____
Pharmacist Name:
(optional)_____Pharmacy:_____
Signature:_____Date:_____