

Colorado Medicaid Prior Authorization Request Form

Daklinza (daclatisvir)

This form **must be signed by prescriber** to request prior authorization for Daklinza beginning October 1, 2015. See the Preferred Drug List (PDL) for details at: <https://www.colorado.gov/hcpf/provider-forms>. Certain documentation is required to accompany this form for approval consideration. **Prescriber must be a physician and must complete and sign this form.**

Please fill in all areas on form. Incomplete forms (including missing required lab values or documentation) will result in a PA denial

Member name: _____ DOB: _____
Medicaid ID: _____ Gender: _____ BMI: _____ CrCl ml/min: _____

This section must be complete AND all documentation must accompany PAR or PA will be denied for incompleteness

Genotype: 3 Does member have Y93H polymorphism? No Yes Unknown

Child-Pugh Score: _____ Pre-tx HCV RNA IU/mL: _____ Hep A&B vaccination series Completed In Progress
(5-9, not A or B) (provide labs/immunization record)

Any fibrosis? (**must provide labs and show calculation for APRI/FIB-4/FibroScan/FibroMeter/FibroTest**) No Yes

Provide scores: Biopsy _____ APRI _____ FIB-4 _____ FibroScan _____ FibroMeter/FibroTest _____
Approvable scores: F3 - F4 >1 >2.2 >9.6kPa >0.58kPa

Provider attests that member is ready to be compliant to the medication regimen Yes

Provider attests that SVR12 and SVR24 will be submitted timely via fax Yes

History of drug/alcohol misuse/abuse? (including medical/recreational marijuana) No Yes

Has member been drug/alcohol free for at least 6 months? No Yes

Attached screens (not more than 30 days old) Marijuana Toxicology ETOH

ALL members must provide initial drug/alcohol screen documentation which must include marijuana. Provide random monthly screens during treatment if member has **history of misuse/abuse within last 2 years**

Prior Treatment: No Yes **Describe with approximate dates:** _____

Indicate member's diagnosis(es) (provide documentation):

- Chronic Hepatitis C Hepatitis B Cirrhosis: CTP A CTP B (must be on transplant list)
 HIV/AIDS Post-transplant On transplant list with less than 1 year on the list projected
 Ascites Variceal bleed Hepatic encephalopathy Leukocytoclastic vasculitis
 Membranoproliferative glomerulonephritis Symptomatic cryoglobulinemia despite mild liver disease
 Hepatocellular carcinoma meeting Milan criteria Severe renal impairment (eGFR < 30mL/min)

Complete current medication list required. Attached? Yes

Is member taking (circle) amiodarone, dabigatran, carbamazepine, phenytoin, rifampin, St. John's wort, other strong CYP3A inducers
 None

Female members: Is member of childbearing potential? No Yes (provide pregnancy test)

Is requested drug being prescribed in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist?

No Yes Identify provider name and specialty (circle above): _____

Initial approval: 8 week supply. Refills: not granted unless required documentation is received.

Physician: _____ Phone: _____ Fax: _____ NPI: _____

Physician signature: _____ Date: _____

(Must be signed by PHYSICIAN for attestation)