Direct-Acting Antiviral (DAA) Agents Used to Treat Chronic Hepatitis C Virus (HCV)
Medication Therapy Worksheet for Louisiana Medicaid Recipients

Note: This worksheet must be completed in full and submitted with supporting documentation where applicable. [See DAA Clinical Authorization Criteria]

Recipient Name:	Medicaid Recipient ID #:		Recipient DOB:	Recipient weight:
Prescriber Name:	Prescriber Specialty:	Medicaid Provider ID #:	Office Contact:	

Medication regimen requested *[Choose one.]*

- ☐ Daclatasvir (Daklinza™)
- ☐ Daclatasvir / Sofosbuvir (Daklinza™/ Sovaldi®)
- ☐ Elbasvir / Grazoprevir (Zepatier®)
- ☐ Glecaprevir / Pibrentasvir (Mavyret™)
- ☐ Ledipasvir / Sofosbuvir (Harvoni®)
- ☐ Ombitasvir / Paritaprevir / Ritonavir with Dasabuvir (Viekira Pak™)
- ☐ Ledipasvir / Sofosbuvir (Authorized Generic (AG) of Harvoni®)
- ☐ Sofosbuvir / Velpatasvir (Epclusa®)
- ☐ Sofosbuvir (Sovaldi®)
- ☐ Sofosbuvir / Velpatasvir / Voxilaprevir (Vosevi™)
- ☐ Sofosbuvir / Velpatasvir (Authorized Generic (AG) of Epclusa®)
  [This form is not necessary because Epclusa® AG is preferred and does not require authorization.]

Duration of therapy requested: ____weeks *[If duration is greater than minimum duration stated per prescribing information, please provide rationale below for extended duration.]*
Reason for extended duration request (if applicable):
Does patient have a diagnosis of Chronic Hepatitis C (HCV)? ☐Yes ☐No Please specify genotype:
Is patient treatment-naïve? ☐Yes ☐No If no, provide previous HCV therapy:
Was previous therapy completed? ☐Yes ☐No If no, provide reason for discontinuation.
Has the patient experienced treatment failure with the preferred product? ☐ Yes ☐ No
Has the patient had an intolerable side effect with the preferred product? ☐ Yes ☐ No
If yes, please explain in detail:
Does the patient have documented contraindication(s) to the preferred product? ☐Yes ☐No
If yes, please explain in detail:
If there is no preferred product that is appropriate to use for the condition being treated, please explain in detail:

By signing below, the prescriber attests that the information provided herein is true and accurate to the best of his/her knowledge. Also, by signing and submitting this request form, the prescriber attests to statements in the 'Attestation' section of the criteria specific to this request.

Physician Signature:* ____ **Date:**_______________

**(Signature stamps and proxy signatures are not acceptable.)*

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