

**North Carolina Department of Health and Human Services
Division of Medical Assistance
EPCLUSA Continuation PA Form**

Recipient Information

1. Recipient Last Name: _____ 2. First Name: _____

3. Recipient ID #: _____ 4. Recipient Date of Birth: _____ 5. Recipient Gender: _____

Prescriber Information

6. Prescribing Provider NPI#: _____

7. Requester Contact Information - Name: _____ Phone #: _____ Ext: _____

Drug Information

8. **EPCLUSA** 9. **28** Per 28 Days

10. Length of Therapy (Check ONE)¹: **Epclusa is preferred for Genotype 3**

___ **4 more weeks** = Genotype 3: without cirrhosis

___ **4 more weeks** = Genotype 3: with compensated cirrhosis (Child-Pugh A)

___ **4 more weeks** = Genotype 3: with decompensated cirrhosis (Child-Pugh B and C) (to be given with ribavirin)

___ **4 more weeks** = Genotype 1,2,4,5,6: without cirrhosis

___ **4 more weeks** = Genotype 1,2,4,5,6: with compensated cirrhosis (Child-Pugh A)

___ **4 more weeks** = Genotype 1,2,4,5,6: with decompensated cirrhosis (Child-Pugh B and C) (to be given with ribavirin)

Clinical Information

1. HCV-RNA (IU/ml) _____ and/or log₁₀ value _____ at week 3 or 4 of treatment cycle (must show less than 25IU/ml or 2log₁₀ reduction in HCV-RNA to continue.)*

* **HCV-RNA lab test results MUST be attached to the PA to be approved.**

Signature of Prescriber: _____ Date: _____

(Prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSC at: (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505