Uniform New Mexico HCV Checklist for Centennial Care *Revision Date = 12/9/2016*

Note: URGENT requests must only be for patients currently on treatment *or* who have already been presented to project ECHO

PATIENT NAME: _____ **DOB:** _____

1. **DIAGNOSIS:** ☐ **Chronic Hepatitis C Infection**
   a. **Genotype** ____ **Subtype** (if applicable)___ **(attach results)**
   b. **HCV RNA Level within the past 3 months: Level:**_____ **Date:**____/_____/____**(attach results)**
   c. **Yes** ☐ **No** ☐ (if yes, circle and include documentation): Does the patient have HIV-1 or Hepatitis B coinfection or one of the following extra-hepatic manifestation of HCV Infection: Lymphoma, Vasculitis, or Renal Disease, insulin resistant DM, debilitating fatigue due to HCV infection (documented as chronic and persistent and still present at time of request), porphyria cutanea tarda, OR is the patient a man who has sex with men with high-risk sexual practices, an active injection drug user (≥ 1 injection in past 3 months), on long-term hemodialysis, a woman of childbearing age who wishes to get pregnant, or an HCV-infected health care worker who performs exposure-prone procedures?

2. **ADDITIONAL REQUIRED LABS (within 3 months of request- please attach results)**

   ☐ AST, ☐ ALT, ☐ Bilirubin, ☐Albumin, ☐ INR, ☐ Platelet count, ☐ Hemoglobin, ☐ Creatinine.
   Also document prior ☐ HBsAg, ☐ anti-HBs, ☐ anti-HBc (Hep B tests within 3 months not required unless at current risk*)

3. ***Yes*** ☐ ***No*** ☐ **LIVER TRANSPLANT** (if yes, check one): ☐In past, date_____. ☐Being considered for transplant.

4. **LIVER ASSESSMENT**
   a. **Yes** ☐ **No** ☐ Does the patient have (circle all that apply) APRI ≥ 0.3 (F1) (use ULN for AST of 40), *OR* Fib-4 ≥ 1.29, *OR* METAVIR Score ≥ F1, OR Transient Elastography Score ≥ 5.0 kPa (F1), *OR* FibroSure ≥ 0.27 (F1), *OR* Fibrometer ≥ F1 predominance [F1], *OR* radiographic imaging/physical exam consistent with cirrhosis (attach relevant results and notes)

5. **Yes** ☐ **No** ☐ Is patient **TREATMENT EXPERIENCED**? If "Yes" with Direct Acting Antivirals (DAA), complete a – e below. If "Yes," but NOT with Direct Acting Antivirals, answer a, b & c only. If "No," go to 6)
   a. List regimen(s) patient has received in past including year and duration of therapy:
      _____
   b. **Yes** ☐ **No** ☐ Unknown ☐ Did patient complete treatment regimen(s)? If "No," reason for discontinuation:
      _____
   c. What was patient's response to therapy? ☐ Unknown. ☐ Relapse (post treatment SVR, then elevated HCV RNA level some time later). ☐ Non-response (HCV RNA remained detectable after complete treatment course)
   d. **Yes** ☐ **No** ☐ For direct-acting antiviral (DAA) failures, is **urgent** retreatment needed? (If yes, circle condition and include documentation): cirrhosis, lymphoma, vasculitis, renal disease
   e. **Yes** ☐ **No** ☐ Have you reviewed the member's case with Project ECHO? If not, health plan may require consultation with Project ECHO.

6. **RESISTANCE TESTING** (please attach results, if applicable)
   a. **Yes** ☐ **No** ☐ Does patient have genotype 1a and Zepatier will be prescribed? If yes, order ☐ NS5A
   b. **Yes** ☐ **No** ☐ Does patient have genotype 3, is treatment naïve + cirrhotic? If yes, order ☐ NS5A
   c. **Yes** ☐ **No** ☐ Does patient have genotype 3, is treatment experienced + non-cirrhotic? If yes, order ☐ NS5A
   d. **Yes** ☐ **No** ☐ **Unknown** ☐ Does patient have prior treatment failure with a direct-acting antiviral (DAA)?
      If yes/unknown, order: ☐ NS5A ☐ NS3

7. **REQUESTED MEDICATION(S)**

Drug:_____ **Dose:** _____ **Duration:** _____ **weeks**

Drug:_____ **Dose:** _____ **Duration:** _____ **weeks**

☐ **I am agreeable to approval and use of alternative and equivalent formulary drug(s) with equal or greater SVR; please substitute and notify me.**

☐ **I am agreeable to approval and use of alternative drug(s), dose(s) and/or duration(s) based on current AASLD/IDSA guidance.**

Comments: _____

NOTE: If you are submitting a request for treatment that is not recommended in the AASLD/IDSA guidance, please submit supporting medical literature.

7. **ADHERENCE POTENTIAL** ☐ **I attest my belief that this patient is capable of full adherence to the above treatment**

SEE ADDITIONAL RECOMMENDATIONS BELOW

Uniform New Mexico HCV Checklist for Centennial Care

8. Important Additional Recommendations:

1. If patient has alcohol or illicit drug abuse history, please refer patient to addiction specialist for counseling and treatment
2. HIV and Hepatitis A screening including HAV Ab should be performed. ***For patients with ongoing risk factors for Hepatitis B, obtain Hepatitis B lab results within 3 months prior to treatment.**
3. Hepatitis A and Hepatitis B vaccination series should be initiated if not already completed (and patient non-immune)
4. If patient has decompensated liver disease (Child-Pugh B or C) it is recommended that treatment be co-managed with a gastroenterologist, infectious disease specialist or hepatologist, and that referral for transplant be strongly considered
5. Patients being considered for retreatment after failure of initial treatment with all-oral therapy should be considered for presentation to Project ECHO (attach notes)