PRIOR AUTHORIZATION PROGRAM REIMBURSEMENT REQUEST FORM

Please note that the patient AND physician must complete this form. **All fields are mandatory and must be completed. Incomplete forms may result in your application being declined.** Please retain a copy of this form for your records.

**Instructions:**
1. **PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS.**
2. The patient/plan member must complete section A.
3. Your physician must complete section B. The cost, if any, of completing this form is at the expense of the patient/plan member.
4. Please return the form to your insurance company via Pharmacy Services at TELUS Health (a service provider of your insurance company) by fax to **1-866-840-1509**, OR mail to TELUS Health, 4141 Dixie Rd. P.O. Box 41154, Mississauga, Ont. L4W 5C9.
5. If you have any questions on the application of this program or the decision on reimbursement, or to inquire on the status of your Reimbursement Request Form, please contact your insurer.

### A. Information to be Completed by Patient

<table>
<thead>
<tr>
<th>Employee or Insured’s Name</th>
<th>Drug Card Number</th>
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<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Patient’s Date of Birth (DD/MM/YYYY)</th>
<th>Relationship to Employee/Insured</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Employee  Spouse  Dependent</td>
</tr>
</tbody>
</table>

Please allow two business days for a response once all information is received and complete. Notification of the results of this request will occur Monday to Friday between 9 am and 4 pm Eastern Time.

Please provide contact information and indicate **ONE** method of preferred contact for notification of the results:

- [ ] E-mail me at: ____________________________
- [ ] Call me (and leave a message if I’m not there) at: ____________________________
- [ ] Fax me at: ____________________________

- [ ] Contact my pharmacy: ____________________________

<table>
<thead>
<tr>
<th>Pharmacy Name</th>
<th>Pharmacy Phone Number</th>
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I certify that the information provided by me is true, correct and complete to the best of my knowledge. I authorize my insurance company, TELUS Health (a service provider of my insurance company), their authorized representatives, agents and service providers to use and exchange this information needed for underwriting, administration and paying claims with any person or organization who has relevant information pertaining to this claim including health professionals, institutions and investigative agencies in the event of an audit. I authorize my insurance company and/or TELUS Health (a service provider of my insurance company) to contact any licensed physician, institution, pharmacy or person who has any records or knowledge of me or my health with respect to this submitted claim.

**SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN** ____________________________

The most current version of this form supersedes all prior versions. The form may be modified without notice to you and we reserve the right to accept only the current version. **Revised September 2017. PREFERRED HEPATITIS-1709**
For Preferred Hepatitis C Therapy: Epclusa (sofosbuvir/velpatasvir), Harvoni (ledipasvir/sofosbuvir), Holkira Pak (ritonavir/paritaprevir/ombitasvir/dasabuvir), Marivet (glecaprevir/pibrentasvir), Sovaldi (sofosbuvir), Technivie (ritonavir/paritaprevir/ombitasvir), Vosevi (sofosbuvir/velpatasvir/voxilaprevir), Zepatier (elbasvir/grazoprevir)

Date: (DD/MMM/YYYY): __ __ / __ __ __ / __ __ __ __

B. Information to be Completed by Prescribing Physician

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Strength</th>
<th>Dose</th>
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| Epclusa (sofosbuvir/velpatasvir), Harvoni (ledipasvir/sofosbuvir), Holkira Pak (ritonavir/paritaprevir/ombitasvir/dasabuvir), Marivet (glecaprevir/pibrentasvir), Sovaldi (sofosbuvir), Technivie (ritonavir/paritaprevir/ombitasvir), Vosevi (sofosbuvir/velpatasvir/voxilaprevir), or Zepatier (elbasvir/grazoprevir) will be eligible for reimbursement only if the patient satisfies the conditions listed below and if the patient does not qualify for coverage under any other drug plan or government mandated program. If the patient is covered under another drug plan or government mandated program, the prior authorization program, as part of your drug benefits, may cover the portion not paid for by the primary plan. If “None of the above criteria” is indicated, the patient will not be eligible for reimbursement. For Quebec plan members, please refer to the RAMQ exception drug criteria, if applicable.

Eligibility Criteria

Genotype 1

Maviret
- Treatment of adults with treatment-naïve genotype 1 chronic hepatitis C (CHC) infection with fibrosis stage F2 or greater status (Metavir scale or equivalent) without cirrhosis (Maximum 8 weeks/168 tablets)
- Treatment of adults with treatment-experienced genotype 1 chronic hepatitis C (CHC) infection with fibrosis stage F2 (without cirrhosis) or greater status (Metavir scale or equivalent) who were previously treated with either a regimen of NS5A inhibitor or with a NS3/4A protease inhibitor but not both classes of inhibitors (Maximum 8 weeks/168 tablets)
- Treatment of adults with treatment-experienced genotype 1 chronic hepatitis C (CHC) infection with compensated cirrhosis who were previously treated with either a regimen of NS5A inhibitor or with a NS3/4A protease inhibitor but not both classes of inhibitors in whom sofosbuvir/velpatasvir/voxilaprevir in contraindicated (Maximum 12 weeks/252 tablets)

Epclusa
- Treatment of adults with genotype 1 chronic hepatitis C (CHC) infection with fibrosis stage F2 or greater status (Metavir scale or equivalent) AND has one of the following:
  - Patients with compensated cirrhosis (Maximum 12 weeks/84 tablets)
  - Patients with decompensated cirrhosis, in combination with ribavirin (Maximum 12 weeks/84 tablets)
  - Non-cirrhotic patients in whom glecaprevir/pibrentasvir is contraindicated (Maximum 12 weeks/84 tablets)

Harvoni
- Treatment of adults with genotype 1 chronic hepatitis C (CHC) infection with fibrosis stage F2 or greater status (Metavir scale or equivalent) AND has one of the following:
  - Treatment-naïve patients without cirrhosis who have pre-treatment Hepatitis C Virus (HCV) RNA < 6 million IU/mL (Maximum 8 weeks/56 tablets)

Zepatier
- Treatment of adults with genotype 1 chronic hepatitis C (CHC) infection with fibrosis stage F2 or greater status (Metavir scale or equivalent) AND has one of the following:
  - Treatment-naïve genotype 1b patients without significant fibrosis or cirrhosis (Maximum 8 weeks/56 tablets)
### Eligibility Criteria

**Vosevi**
- Treatment of adults with genotype 1 chronic hepatitis C (CHC) infection with fibrosis stage F2 or greater status (Metavir scale or equivalent), without decompensated cirrhosis, who have previously been treated with an HCV regimen containing an NS5A inhibitor, or an HCV regimen containing sofosbuvir without an NS5A inhibitor (Maximum 12 weeks/84 tablets).

**Non-preferred agents due to the availability of more cost-effective agents:**
- Daklinza (combined with Sovaldi or Sunvepra)
- Harvoni (for high viral loads),
- Galexos
- Sovaldi
- Zepatier (with ribavirin)

### Genotype 2

**Maviret**
- Treatment of adults with treatment-naive genotype 2 chronic hepatitis C (CHC) infection with fibrosis stage F2 or greater status (Metavir scale or equivalent) without cirrhosis (Maximum 8 weeks/168 tablets)

**Epclusa**
- Treatment of adults with genotype 2 chronic hepatitis C (CHC) infection with fibrosis stage F2 or greater status (Metavir scale or equivalent) AND has one of the following:
  - Patients with compensated cirrhosis (Maximum 12 weeks/84 tablets)
  - Patients with decompensated cirrhosis, in combination with ribavirin (Maximum 12 weeks/84 tablets)
  - Non-cirrhotic patients in whom glecaprevir/pibrentasvir is contraindicated (Maximum 12 weeks/84 tablets)

**Vosevi**
- Treatment of adults with genotype 2 chronic hepatitis C (CHC) infection with fibrosis stage F2 or greater status (Metavir scale or equivalent), without decompensated cirrhosis, who have previously been treated with an HCV regimen containing an NS5A inhibitor, or an HCV regimen containing sofosbuvir without an NS5A inhibitor (Maximum 12 weeks/84 tablets).

**Non-preferred agent due to the availability of more cost-effective agents:**
- Daklinza (combined with Sovaldi)
- Sovaldi

### Genotype 3

**Maviret**
- Treatment of adults with treatment-naive genotype 3 chronic hepatitis C (CHC) infection with fibrosis stage F2 or greater status (Metavir scale or equivalent) without cirrhosis (Maximum 8 weeks/168 tablets)

**Epclusa**
- Treatment of adults with genotype 3 chronic hepatitis C (CHC) infection with fibrosis stage F2 or greater status (Metavir scale or equivalent) AND has one of the following:
  - Patients with compensated cirrhosis (Maximum 12 weeks/84 tablets)
  - Patients with decompensated cirrhosis, in combination with ribavirin (Maximum 12 weeks/84 tablets)
  - Non-cirrhotic patients in whom glecaprevir/pibrentasvir is contraindicated.

**Vosevi**
- Treatment of adults with genotype 3 chronic hepatitis C (CHC) infection with fibrosis stage F2 or greater status (Metavir scale or equivalent), without decompensated cirrhosis, who have previously been treated with an HCV regimen containing an NS5A inhibitor, or an HCV regimen containing sofosbuvir without an NS5A inhibitor (Maximum 12 weeks/84 tablets).
Eligibility Criteria

regimen containing an NS5A inhibitor, or an HCV regimen containing sofosbuvir without an NS5A inhibitor (Maximum 12 weeks/84 tablets).

Non-preferred agents due to the availability of more cost-effective agents:

- Daklinza (combined with Sovaldi)
- Sovaldi
- Harvoni
- Zepatier (combined with Sovaldi)

Genotype 4

Maviret
- Treatment of adults with treatment-naïve genotype 4 chronic hepatitis C (CHC) infection with fibrosis stage F2 or greater status (Metavir scale or equivalent) without cirrhosis (Maximum 8 weeks/168 tablets)

Technivie
- Treatment of adults with genotype 4 chronic hepatitis C virus (CHC) infection with fibrosis stage F2 or greater status without cirrhosis who are either treatment naive or previously treated with peginterferon (pegIFN) and ribavirin, AND satisfies all of the following (Maximum 12 weeks/168 tablets):
  - Child-Pugh score of A,
  - No previous HCV regimens containing a protease inhibitor (eg. Incivek, Victrelis, Galexos).
  - Non-cirrhotic patients in whom glecaprevir/pibrentasvir is contraindicated.

Epclusa
- Treatment of adults with genotype 4 chronic hepatitis C (CHC) infection with fibrosis stage F2 or greater status (Metavir scale or equivalent) AND has one of the following:
  - Patients with compensated cirrhosis (Maximum 12 weeks/84 tablets)
  - Patients with decompensated cirrhosis, in combination with ribavirin (Maximum 12 weeks/84 tablets)
  - Non-cirrhotic patients in whom glecaprevir/pibrentasvir is contraindicated.

Vosevi
- Treatment of adults with genotype 4 chronic hepatitis C infection with fibrosis stage F2 or greater status (Metavir scale or equivalent), without decompensated cirrhosis, who have previously been treated with an HCV regimen containing an NS5A inhibitor, or an HCV regimen containing sofosbuvir without an NS5A inhibitor (Maximum 12 weeks/84 tablets).

Non-preferred agents due to the availability of more cost-effective agents:

- Daklinza (combined with Sunvepra)
- Sovaldi
- Galexos
- Zepatier

Genotypes 5 and 6

Maviret
- Treatment of adults with treatment-naïve genotype 5 or 6 chronic hepatitis C (CHC) infection with fibrosis stage F2 or greater status (Metavir scale or equivalent) without cirrhosis (Maximum 8 weeks/168 tablets)

Epclusa
- Treatment of adults with genotypes 5 and 6 chronic hepatitis C (CHC) infection with fibrosis stage F2 or greater status (Metavir scale or equivalent) AND has one of the following:
  - Patients with compensated cirrhosis (Maximum 12 weeks/84 tablets)
  - Patients with decompensated cirrhosis, in combination with ribavirin (Maximum 12 weeks/84 tablets)
  - Non-cirrhotic patients in whom glecaprevir/pibrentasvir is contraindicated.

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Eligibility Criteria

Vosevi
- Treatment of adults with genotypes 5 and 6 chronic hepatitis C (CHC) infection with fibrosis stage F2 or greater status (Metavir scale or equivalent), without decompensated cirrhosis, who have previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor (Maximum 12 weeks/84 tablets).

OR
- None of the above criteria applies.

Additional Information: __________________________________________________________________________

Physician Information

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<th>Physician’s Name</th>
<th>License Number</th>
<th>Telephone Number</th>
<th>Fax Number</th>
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