

DISTRICT OF COLUMBIA ~ DEPARTMENT OF HEALTH ~ ADAP

Daclatasvir tablet (Daklinza™)

PRIOR AUTHORIZATION PROGRAM Request Form – Initial Request (12 weeks maximum)

CLIENT'S NAME: \_\_\_\_\_ ADAP ID: \_\_\_\_\_

CLIENT'S DATE OF BIRTH \_\_\_\_\_ ADAP Pharmacy \_\_\_\_\_

**DC ADAP Policy:** Daklinza™ (Daclatasvir) is an inhibitor of hepatitis C virus (HCV) nonstructural protein 5A (NS5A). Daclatasvir is available as 60 mg and 30 mg tablets for oral administration.

**Daklinza™ requires prior approval for coverage. Allow up to 96 hours for completion of request.**

**Please fax (1) supportive medical letter of necessity of necessity (2) applicable diagnostic tests and (3) patient signed acknowledgement and commitment letter**

**Indication for Use:**

Daclatasvir is indicated for use with sofosbuvir for the treatment of chronic hepatitis C (CHC) genotype 3 infection as a component of a combination antiviral treatment regimen. The sustained virologic response (SVR) rates are reduced in patients with cirrhosis. The recommended duration is 12 weeks.

**Criteria for use:**

*Please complete and check all that apply:*

1. Medical Provider is experienced in the care of HIV/hepatitis C infection, or in consultation with an infectious disease specialist or gastroenterologist.  
YES  NO
2. Does client have adherence issues with antiretroviral or other medications?  
YES  NO
3. Client is not being treated with medications that are not recommended for use with or contraindicated with sofosbuvir or daclatasvir (refer to product labeling).  
YES  NO
4. Client is currently receiving strong CYP3A inhibitors, e.g. clarithromycin, ritonavir  
YES  NO
5. Client is currently receiving moderate CYP3A inducers, e.g. efavirenz, etravirine  
YES  NO
6. Client is currently receiving strong CYP3A inducers, e.g. phenytoin, carbamazepine  
YES  NO
7. Client's has confirmed clinical diagnosis of Hepatitis C, genotype 3.  
YES  NO  Other genotype \_\_\_\_\_ (specify)

8. Client is not pregnant or attempting to become pregnant and/or female partner of a male patient is not pregnant.  
 YES  NO
9. Does client have decompensated liver disease?  
 YES  NO
10. Client has cirrhosis?  
 YES  NO
11. Client has not previously been treated with sofosbuvir?  
 YES  NO
12. Client has a FibroSure score of \_\_\_\_\_.  
 Date of test \_\_\_\_\_ or biopsy proven score of \_\_\_\_\_ Date: \_\_\_\_\_
13. Client has had a positive hepatitis C viral load taken within the last 6 months.  
 YES  NO
14. Client's anticipated start date of Daklinza™ is \_\_\_\_\_.
15. Client's anticipated duration of CHC treatment is \_\_\_\_\_ weeks.
16. Client's dose of Daklinza™ is \_\_\_\_\_ mg.

**Recommended dosage and administration:** The recommended dose is one 60 mg tablet orally once a day with or without food. Daclatasvir should be administered in combination with sofosbuvir to treat chronic hepatitis C in adults. The optimal duration of therapy has not been established for patients with cirrhosis. The prescribing information for sofosbuvir should be referenced for specific guidance.

**Dose modification due to Drug-Drug Interactions (*Reference Only*)**

Concomitant Strong CYP3A Inhibitors	Concomitant Moderate CYP3A Inducers	Concomitant Strong CYP3A Inducers
Daclatasvir 30 mg daily	Daclatasvir 90 mg daily	Contraindicated

Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name (Print): \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Fax Completed Form to Clinical Pharmacy Associates: Fax: 1 (888) 971-7229**

**Phone: 1 (800) 745-0434 ext 150 Attention: Prior Approval Program**

Approval: YES  NO  Date \_\_\_\_\_ Initials \_\_\_\_\_ Office use only  
 Reason for denial \_\_\_\_\_

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