

Please ensure each section is completed to avoid delays.

Section 1 – Prescriber Information		Section 2 – Patient Information	
First Name _____	Last Name _____	First Name _____	Last Name _____
Mailing Address _____		Date of Birth _____/_____/_____ (day/month/year)	
Telephone Number _____	Fax Number _____	Health Services Number _____	
Section 3 – Requested Drug Regimen (see Appendix A for specific EDS criteria)			
Select ONE from the following funded treatment regimens of the following medications:			
<u>Genotype 1</u> <input type="checkbox"/> Eplclusa (12 weeks) <input type="checkbox"/> Eplclusa <u>and</u> Ibavvyr (12 weeks) <input type="checkbox"/> Harvoni (8 weeks) <input type="checkbox"/> Harvoni (12 weeks) <input type="checkbox"/> Harvoni <u>and</u> Ibavvyr (12 weeks) <input type="checkbox"/> Harvoni (24 weeks) <input type="checkbox"/> Zepatier (8 weeks) <input type="checkbox"/> Zepatier (12 weeks) <input type="checkbox"/> Zepatier <u>and</u> Ibavvyr (16 weeks)	<u>Genotype 2</u> <input type="checkbox"/> Eplclusa (12 weeks) <input type="checkbox"/> Eplclusa <u>and</u> Ibavvyr (12 weeks) <input type="checkbox"/> Sovaldi <u>and</u> Ibavvyr (12 weeks)	<u>Genotype 3</u> <input type="checkbox"/> Daklinza <u>and</u> Sovaldi (12 weeks) <input type="checkbox"/> Daklinza, Sovaldi <u>and</u> Ibavvyr (12 weeks) <input type="checkbox"/> Eplclusa (12 weeks) <input type="checkbox"/> Eplclusa <u>and</u> Ibavvyr (12 weeks) <input type="checkbox"/> Sovaldi <u>and</u> Ibavvyr (24 weeks)	<u>Genotype 4</u> <input type="checkbox"/> Eplclusa (12 weeks) <input type="checkbox"/> Eplclusa <u>and</u> Ibavvyr (12 weeks) <input type="checkbox"/> Zepatier (12 weeks) <input type="checkbox"/> Zepatier <u>and</u> Ibavvyr (16 weeks) <u>Genotypes 5 or 6</u> <input type="checkbox"/> Eplclusa (12 weeks) <input type="checkbox"/> Eplclusa <u>and</u> Ibavvyr (12 weeks)
<u>Vosevi (For Treatment-Experienced Patients Only)</u>			
<input type="checkbox"/> Vosevi (12 weeks) for all genotypes Concerning Vosevi, treatment-experienced patients are those who have failed prior therapy with a HCV regimen containing: <ol style="list-style-type: none"> 1. NS5A inhibitor (daclatasvir (Daklinza), elbasvir (part of Zepatier), ledipasvir (part of Harvoni), ombitasvir (part of Holkira Pak), velpatasvir (part of Eplclusa)) for genotype 1, 2, 3, 4, 5 or 6; OR 2. Sofosbuvir (Sovaldi) without an NS5A inhibitor for genotype 1, 2, 3 or 4. 			
<u>Reference generic names:</u>			
Daklinza (daclatasvir)	Harvoni (ledipasvir/sofosbuvir)	Sovaldi (sofosbuvir)	Zepatier (elbasvir/grazoprevir)
Eplclusa (sofosbuvir/velpatasvir)	Ibavvyr (ribavirin)	Vosevi (sofosbuvir/velpatasvir/voxilaprevir)	
Section 4 – Clinical Information			
Confirmed diagnosis of chronic hepatitis C infection with detectable HCV RNA in the last six months: <input type="checkbox"/> Yes HCV Genotype: _____			
Relevant medical history: <input type="checkbox"/> Non-cirrhotic <input type="checkbox"/> Compensated cirrhosis <input type="checkbox"/> Decompensated cirrhosis <input type="checkbox"/> Liver transplant recipient			
HCV treatment history: <input type="checkbox"/> Treatment-naïve <input type="checkbox"/> Treatment-experienced			
If treatment-experienced, list drugs tried and dates of therapy: _____			
Response to prior treatment: <input type="checkbox"/> Null response <input type="checkbox"/> Relapse <input type="checkbox"/> Virologic breakthrough or rebound <input type="checkbox"/> Intolerance			
Signature (Required) _____		Date: _____/_____/_____ (day/month/year)	

DPEB INTERNAL USE ONLY <input type="checkbox"/> SS <input type="checkbox"/> P2

Please submit the completed form by:

- Fax to 306-798-1089; or
 - Email to DPEB@health.gov.sk.ca; or
 - Mail to the Drug Plan and Extended Benefits Branch, 2nd floor, 3475 Albert Street, Regina, SK S4S 6X6
- Designated Prescribers or authorized clinic staff may also submit a request by phone to: 306-787-8744 (in Regina) or 1-800-667-2549 (toll-free).