TEXAS HIV MEDICATION PROGRAM (THMP)
HCV DIRECT-ACTING ANTIVIRAL MEDICAL CERTIFICATION FORM

Fax to (512) 989-4003

(TO BE COMPLETED BY PHYSICIAN) **Texas HIV Medication Code (if known)** _____

The information on this form is necessary to determine the patient's eligibility for program-supplied, HIV-related therapy as prescribed by you. All information on this form will be kept strictly confidential by the Department of State Health Services. Personal identifying information is never released.

PATIENT INFORMATION

Full Name: _____

Mailing Address: _____ Apt. # _____

City, State, Zip: _____ Phone # (_____) _____

Date of Birth: _____/_____/_____ Social Security Number: _____
Month Day Year

*****This form is intended as a supplement to the standard THMP Medical Certification Form and should be submitted only if HCV DAAs are being requested for your patient.*****

PRESCRIBED HCV DAAs (Note that this program only covers the HCV DAAs listed below):

☐ **DAKLINZA (daclatasvir)** ☐ **30 mg/day -OR-** ☐ **60 mg/day -OR-** ☐ **90 mg/day**
☐ **12 weeks -OR-** ☐ **24 weeks**

☐ **EPCLUSA (sofosbuvir/velpatasvir) 12 weeks**

☐ **HARVONI (ledipasvir/sofosbuvir) 12 weeks**

☐ **MAVYRET (glecaprevir/pibrentasvir)**
- ☐ **8 weeks**
- ☐ **12 weeks**
- ☐ **16 weeks**

☐ **Ribavirin (specify daily dosage)**
- ☐ **800 mg/day**
- ☐ **1000 mg/day**
- ☐ **1200 mg/day**
- ☐ **1400 mg/day**

☐ **SOVALDI (sofosbuvir) ***
- ☐ **12 weeks**
- ☐ **16 weeks**
- ☐ **24 weeks**

☐ **TECHNIVIE (ombitasvir/paritaprevir/ritonavir) 12 weeks**

☐ **VIEKIRA XR (ombitasvir-paritaprevir-ritonavir and dasabuvir)**
- ☐ **12 weeks**
- ☐ **24 weeks**

☐ **VOSEVI (sofosbuvir/velpatas/voxilaprevir) 12 weeks**

☐ **ZEPATIER (elbasvir-grazoprevir)**
- ☐ **12 weeks**
- ☐ **16 weeks**

(concluded on next page)

By signing this form, I certify that the following is true:

1. I am experienced in HCV care or am treating HCV in collaboration with a specialist in HCV care.
2. I attest that this patient has not previously failed to complete therapy with DAA for HCV due to patient non-adherence to therapy.
3. I attest that this patient does not have any contraindications to the prescribed DAA and/or is not taking a medication that is contraindicated with the prescribed DAA.
4. I attest that this patient is competent and willing to be treated and adhere to treatment guidelines, including receiving required laboratory tests.
5. If ribavirin is prescribed, I attest that this patient is not pregnant (if female) or (if male) does not have a female partner who is pregnant. I attest that my patient is aware that Ribavirin may cause birth defects and/or death of the exposed fetus and that extreme care must be taken to avoid pregnancy in female patients and in female partners of male patients. My patient has been instructed to use at least two forms of effective contraception during treatment and for six months after treatment has been stopped. For female patients, I will perform pregnancy testing monthly during ribavirin tablet therapy and for six months after therapy has stopped.
6. I agree to monitor the recommended clinical and laboratory parameters before, during and after treatment, and as clinically indicated.
7. I agree to maintain an appropriate treatment plan for this patient.
8. I understand that I must notify the THMP program if the patient is non-adherent to therapy for more than seven days, and that eligibility will be suspended if this happens.
9. This patient is not currently receiving HCV DAAs through a Pharmacy Assistance Program (PAP).

In order to assess the effectiveness of this medication, we must receive follow-up data and documentation on enrolled patients. Please provide contact information for your office so we may follow up on treatment progress at 8 weeks periodically. Please note that an inability to respond to program inquiries may result in the discontinuation of HCV DAAs through this program.

Person in your office to contact: _____

Best day/time to call: _____

Eligibility will be denied or the client will be dis-enrolled for the following reasons:

- **Patient has previously failed to complete therapy with DAA for HCV due to patient nonadherence to therapy.**
- **Patient is non-adherent to therapy for more than seven days**
- **Insufficient resources to procure DAA (limited funds are available for HCV DAA treatment pilot)**
- **Exceptions will be considered for circumstances beyond the prescriber or patient's control.**

By signing this form, I attest that this patient is a medically suitable candidate for HCV DAA treatment:

PHYSICIAN SIGNATURE:_____ TX MD/DO LICENSE #: _____

PRINTED NAME OF PHYSICIAN:_____

OFFICE ADDRESS:_____

TELEPHONE:_____ DATE____/____/____

Texas HIV Medication Program, ATTN: MSJA – MC 1873, PO Box 149347, Austin, TX 78714-9347

(6/2020)