FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Harvoni® & ledipasvir/sofosbuvir Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Chronic Hepatitis C virus (HCV)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Document the patient's HCV genotype:* _____

Will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has a diagnosis of chronic hepatitis C genotype 1, 4, 5, or 6?* ❑ **Yes** ❑ **No**

**Please note: Chart documentation of the above is required to be submitted along with this fax.*

Select if the requested drug is prescribed by or in consultation with one of the following specialists:

- ❑ Gastroenterologist
- ❑ Hepatologist
- ❑ HIV specialist certified through the American Academy of HIV Medicine
- ❑ Infectious disease specialist

Is the patient a liver transplant recipient? ❑ **Yes** ❑ **No**

Does the patient have cirrhosis? ❑ **Yes** ❑ **No**

If "yes" to the above question, will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has cirrhosis?* ❑ **Yes** ❑ **No**

**Please note: Chart documentation of the above is required to be submitted along with this fax.*

Does the patient have decompensated liver disease (e.g., Child-Pugh Class B or C)?* ❑ **Yes** ❑ **No**

If "yes" to the above question, will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has decompensated liver disease (e.g., Child-Pugh Class B or C)?* ❑ **Yes** ❑ **No**

**Please note: Chart documentation of the above is required to be submitted along with this fax.*

Will the requested drug be used in combination with ribavirin? ❑ **Yes** ❑ **No**

If "no" to the above question, is the patient ribavirin ineligible? ❑ **Yes** ❑ **No**

Select the patient's treatment experience:

- ❑ Treatment naive
- ❑ Treatment failure with a previous treatment regimen that included Sovaldi (sofosbuvir) (except in combination with Olysio [simeprevir])
- ❑ Treatment failure with a previous treatment regimen that included peginterferon plus ribavirin
- ❑ Treatment failure with an HCV protease inhibitor (e.g., Incivek [telaprevir], Olysio [simeprevir], Victrelis [boceprevir]) plus peginterferon plus ribavirin

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Harvoni® & ledipasvir/sofosbuvir Prior Authorization Request Form (Page 2 of 2)

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Will the patient be receiving the requested drug in combination with another HCV direct acting antiviral agent (e.g., Sovaldi [sofosbuvir], Olysio [simeprevir])? ❑ **Yes** ❑ **No**

For genotype 1, will medical records (e.g., chart notes, laboratory values) be submitted documenting a pre-treatment HCV RNA level?* ❑ **Yes** ❑ **No**

Document the pre-treatment HCV RNA level: _____ iU/mL Date: _____

**Please note: Chart documentation of the above is required to be submitted along with this fax.*

For generic ledipasvir/sofosbuvir requests only, also answer the following

Select if the patient has had trial and failure, contraindication or intolerance to the following:

- ❑ Brand Epclusa (sofosbuvir/velpatasvir)
- ❑ Brand Harvoni (ledipasvir/sofosbuvir)
- ❑ Mavyret (glecaprevir/pibrentasvir)

Is this request for the continuation of prior generic ledipasvir/sofosbuvir therapy? ❑ **Yes** ❑ **No**

If the patient is less than 12 years old, please document the patient's weight: _____ lbs/kg

Quantity Limit Requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.