MC-Rx
Powered by ProCare Rx

Daklinza®

Ticket #: ____________________ **Request Date:** ______________________ **Request Time:** ______________________

Daklinza® 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 requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

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 HCV genotype 1 or 3 infection?* ❑ **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? ❑ **Yes** ❑ **No**

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

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

Select if Daklinza will be used in combination with the following:
❑ Sovaldi
❑ Ribavirin

Select if Daklinza is prescribed by or in consultation with one of the following specialists:
❑ Gastroenterologist ❑ HIV specialist certified through the American Academy of HIV Medicine
❑ Hepatologist ❑ Infectious disease specialist

Has the patient failed a prior HCV NS5A-containing regimen (e.g., Daklinza)? ❑ **Yes** ❑ **No**

Select if the patient has had trial and failure, contraindication, or intolerance to the following, if applicable for the patient's genotype:
❑ Epclusa
❑ Harvoni
❑ Zepatier

Is the patient currently on Daklinza plus Sovaldi therapy? ❑ **Yes** ❑ **No**

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: ____

Please note that this form is to be completed by the prescribing physician. This document and others, if attached, contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

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

____

____

Authorized Medical Signature:	
Telephone:	**Date:**

<u>When Completed Return To</u>:

MC-Rx Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

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

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