MC-Rx
Powered by ProCare Rx

**Harvoni®**

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

# Harvoni® Prior Authorization Request Form (Page 1 of 2)

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

| **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 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 Harvoni 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

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

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

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

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

Will Harvoni 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 an NS5A inhibitor (e.g., Daklinza [daclatasvir])
- ❑ 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

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

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.**

# Harvoni® Prior Authorization Request Form (Page 2 of 2)

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**For genotype 1, also answer the following:**

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.*

**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?**

_______________________________________________________________________________

_______________________________________________________________________________

| **Authorized Medical Signature:** | |
|---|---|
| **Telephone:** | **Date:** |

**When Completed Return To:**

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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