MC-Rx
Powered by ProCare Rx

Olysio®

Ticket #: _____ **Request Date:** _____ **Request Time:** _____

Olysio® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
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 1a, 1b, or 4?* ❑ **Yes** ❑ **No**

For genotype 1a, does the patient have the NS3 Q80K polymorphism?* ❑ **Yes** ❑ **No**

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

Has the patient experienced failure with a previous treatment regimen that includes Olysio or other HCV NS3/4A protease inhibitors [e.g., Incivek (telaprevir), Victrelis (boceprevir)]? ❑ **Yes** ❑ **No**

Does the patient have decompensated liver disease (e.g., Child-Pugh Class B or C)? ❑ **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**

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

Will Olysio be used in combination with peginterferon alfa and ribavirin? ❑ **Yes** ❑ **No**

Will Olysio be used in combination with Sovaldi (sofosbuvir)? ❑ **Yes** ❑ **No**

Select if Olysio 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 this request for continuation of prior Olysio therapy? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to Harvoni therapy? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to Zepatier therapy? ❑ **Yes** ❑ **No**

Does the patient have NS5A inhibitor resistant-associated variants as confirmed by commercially available assays? ❑ **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: _____

Olysio® Prior Authorization Request Form (Page 2 of 2)

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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:**

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.