MC-Rx
Powered by ProCare Rx

Zepatier®

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

Zepatier® 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 1a, 1b, or 4?* ❑ **Yes** ❑ **No**

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

Select if the following applies to the patient:

- ❑ Patient is treatment-naïve
- ❑ Patient has prior failure to peginterferon alfa plus ribavirin treatment
- ❑ Patient has prior failure to peginterferon alfa plus ribavirin treatment plus a HCV NS3/4A protease inhibitor (e.g., boceprevir, simeprevir, or telaprevir)

Will Zepatier be used in combination with ribavirin? ❑ **Yes** ❑ **No**

Has the patient been tested for the presence of NS5A resistance-associated polymorphisms? ❑ **Yes** ❑ **No**

Does the patient have baseline NS5A resistance-associated polymorphisms (i.e., polymorphisms at amino acid positions 28, 30, 31, or 93)? ❑ **Yes** ❑ **No**

Select if Zepatier 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

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

Does the patient have moderate to severe hepatic impairment (e.g., Child-Pugh Class B or C)? ❑ **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: _____

Zepatier® 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.