Prior Authorization Request Form for

daclatasvir (**Daklinza**), sofosbuvir/velpatasvir **(Epclusa),** ledipasvir/sofosbuvir **(Harvoni),** glecaprevir/pibrentasvir **(Mavyret),** simeprevir **(Olysio),** sofosbuvir **(Sovaldi),** itaprevir/ritonavir/ombitasvir **(Technivie),** grazoprevir/elbasvir **(Zepatier),** paritaprevir /ritonavir/ombitasvir/dasabuvir **(Viekira XR and Viekira Pak)**

7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: _____ Secure Fax #: _____

Please indicate which medication is being prescribed: _____

Step 2 **Please complete the clinical assessment:**

1. **The branded agents on the top of this form are the preferred agents for Tricare.** **If the authorized generics of either Epclusa or Harvoni are required, please stop filling out this form and complete the separate PA form specific for the authorized generic product.**	☐ Acknowledged. Proceed to question **2**	
2. **Is the requested medication Harvoni or Sovaldi?**	☐ Yes Proceed to question **3**	☐ No Proceed to question 4
3. **Is the patient greater than or equal to 3 years of age?**	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
4. **Is the patient greater than or equal to 18 years of age?**	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. **Is the requested medication prescribed by or in consultation with a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician?**	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**

Prior Authorization Request Form for

daclatasvir (**Daklinza**), sofosbuvir/velpatasvir **(Epclusa),** ledipasvir/sofosbuvir **(Harvoni),** glecaprevir/pibrentasvir **(Mavyret),** simeprevir **(Olysio),** sofosbuvir **(Sovaldi),** itaprevir/ritonavir/ombitasvir **(Technivie),** grazoprevir/elbasvir **(Zepatier),** paritaprevir /ritonavir/ombitasvir/dasabuvir **(Viekira XR and Viekira Pak)**

6. Does the patient have laboratory evidence of chronic hepatitis C virus (HCV) infection?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. What is the HCV genotype?	☐ **Genotype 1a - Sign and date below** ☐ **Genotype 1b or other genotype 1 subtype - Sign and date below** ☐ **Genotype 2 - Sign and date below** ☐ **Genotype 3 - Sign and date below** ☐ **Genotype 4 - Sign and date below** ☐ **Genotype 5 - Sign and date below** ☐ **Genotype 6 - Sign and date below** ☐ **All others – STOP - Coverage not approved**	

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

_____ _____

Prescriber Signature Date

[08 April 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: