TRICARE Prior Authorization Request Form for
ledipasvir/sofosbuvir **(Harvoni),** grazoprevir/elbasvir **(Zepatier)**

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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.

Prior authorizations will expire in 1 year. PA must be resubmitted.

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 generic of Harvoni is 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 prescribed by a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician?	☐ Yes **Sign and date below**	☐ No Proceed to question **3**
3. Is the requested medication prescribed in consultation with a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a detectable hepatitis C viral load?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. What is the requested medication?	☐ Harvoni - Proceed to question **6** ☐ Zepatier - Proceed to question **7**	

6. Does the patient have a genotype 1, 4, 5, or 6 hepatitis C virus (HCV) infection?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
7. Does the patient have a genotype 1 or 4 hepatitis C virus (HCV) infection?	☐ Yes **Sign and date below**	☐ No **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 January 2025]

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