carolina complete health

Pharmacy Prior Approval Request for Epclusa: Continuation PA Form

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. ____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: __28__
11. Length of Therapy (in days): ☒ 4 Weeks (Do not change. Only 4 weeks can be approved with this form.)

Clinical Information

1. Have HCV RNA labs been collected four (4) or more weeks after the initial prescription fill date? (Medical documentation with results are required)? ☐ **Yes** ☐ **No**
2. Do the results of the HCV RNA labs indicate a response to therapy (>/= 2 log reduction in HCV RNA or HCV RNA < 25IU/ml)? ☐ **Yes** ☐ **No**

   At week 4 of the treatment cycle:

   HCV RNA (IU/ml): _____
   And/or log 10 value: _____

   Before treatment documented on original Prior Authorization request:

   HCV RNA (IU/ml): _____
   And/or log 10 value: _____

3. Has the beneficiary exhibited any sign of high risk behavior (ex. recurring alcoholism, IV drug use, etc.)?
   ☐ **Yes** ☐ **No**
4. Has the beneficiary failed to complete HCV disease evaluation appointments or procedures?
   ☐ **Yes** ☐ **No**
5. During the initial course of therapy, was the beneficiary compliant with the prescribed medication regimen?
   ☐ **Yes** ☐ **No**
6. Has the beneficiary's medication fill history been reviewed for compliance? ☐**Yes** ☐**No**

Signature of Prescriber:_____Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (866)-399-0929 Pharmacy PA Call Center: (833) 585-4309