carolina complete health

Pharmacy Prior Approval Request for Harvoni Tablet/Pellet Pack/Ledipasvir-Sofosbuvir: PA Request

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): ☐ 8 Weeks ☐12 Weeks ☐24 Weeks

Clinical Information

Total length of therapy being requested (Check ONE):

- ☐ **8 weeks** = Genotype 1 - Treatment-naïve without cirrhosis who have pre-treatment HCV RNA less than 6 million IU/mL
- ☐ **12 weeks** = Genotype 1, 4, 5, or 6 - Treatment-naïve and treatment-experienced without cirrhosis or with compensated cirrhosis (Child-Pugh A)
- ☐ **24 weeks** = Treatment-experienced with compensated cirrhosis (Child-Pugh A)
- ☐ **Harvoni + ribavirin 12 weeks** = Genotype 1 - Treatment-naïve and treatment-experienced with decompensated cirrhosis (Child-Pugh B or C) or Genotype 1 or 4 – Treatment-naïve and treatment-experienced liver transplant recipients without cirrhosis, or with compensated cirrhosis (Child-Pugh A)

1. Is the beneficiary 3 years or older w/ a diagnosis of Chronic Hepatitis C (CHC) infection w/ confirmed genotype 1, 4, 5 or 6 infection without cirrhosis or w/ compensated cirrhosis, or genotype 1 infection w/ decompensated cirrhosis, in combination w/ ribavirin; or genotype 1 or 4 infection who are liver transplant recipients without cirrhosis or w/ compensated cirrhosis, in combination w/ ribavirin? ☐ **Yes** ☐ **No Genotype:** _____
2. Are medical records documenting the diagnosis of chronic hepatitis C with genotype and subtype attached? ☐ **Yes** ☐ **No**
   ****Lab test results. MUST be attached to the PA to be approved.****
3. Does the beneficiary have a documented quantitative HCV RNA at baseline that was tested within the past 6 months (medical documentation required)? ☐ **Yes** ☐ **No HCV RNA (IU/ml):** _____ and/or **log10 value** _____
4. Will Harvoni be used in combination with other drugs containing sofosbuvir? ☐ **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: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/