

Harvoni® (Ledipasvir/Sofosbuvir) Initiation Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____
 Pharmacy NPI: _____ Pharmacy Phone: _____ Pharmacy Fax: _____
 Pharmacy Name: _____ Pharmacist Name: _____
 Prescriber NPI: _____ Prescriber Name: _____ Specialty: _____
 Prescriber Phone: _____ Prescriber Fax: _____ Start Date: _____
 Drug Name: _____ NDC: _____ Member's Weight (kg): _____ Date Taken: _____

Clinical Information

1. HCV Genotype (including subtype): _____ Date Determined: _____
2. METAVIR Equivalent Fibrosis Stage: _____ Testing Type: _____
Date Fibrosis Stage Determined: _____
3. Pre-treatment viral load in the last 12 months (must be within last 3 months if requesting 8-week regimen):
Pre-treatment viral load: _____ Date Taken: _____
For METAVIR score of <F1, 2nd test must confirm chronic HCV diagnosis at least 6 months after 1st test.
Prior pre-treatment viral load or antibody test: _____ Date Taken: _____
4. Does member have decompensated hepatic disease (CTP class B or C)? Yes _____ No _____
5. Is the member currently on hospice or does the member have a limited life expectancy (less than 12 months) that cannot be remediated by treating HCV? Yes _____ No _____
6. Has the member been evaluated by a gastroenterologist, infectious disease specialist, or a transplant specialist within the past 3 months? Yes _____ No _____
7. If yes, please include name of specialist recommending hepatitis C treatment: _____
8. Has the member been previously treated for hepatitis C? Yes _____ No _____
9. If yes, please indicate previous treatment regimen and reason for failure (relapser, null-responder, partial responder): _____
10. Please indicate requested drug strength **and** regimen below:

<input type="checkbox"/> Harvoni® 90mg/400mg	<input type="checkbox"/> once daily x 56 days (8 weeks)
<input type="checkbox"/> Harvoni® 45mg/200mg	<input type="checkbox"/> once daily x 84 days (12 weeks)
<input type="checkbox"/> Harvoni® 33.75mg/150mg	<input type="checkbox"/> once daily with weight-based ribavirin x 84 days (12 weeks)
<input type="checkbox"/> Other: _____	
11. For members 6 years of age or older requesting the oral pellet formulation, please provide a patient-specific, clinically significant reason why the tablet is not appropriate: _____
12. Has the member signed the intent to treat contract**? Yes _____ No _____ ***Required for processing of request ***
13. Has the member been counseled on the harms of illicit IV drug use and alcohol use and agreed to not use illicit IV drugs or alcohol while on or after they finish hepatitis C treatment? Yes _____ No _____
14. Has the member initiated immunization with the hepatitis A and B vaccines? Yes _____ No _____
15. For women of childbearing potential (and male patients with female partners of childbearing potential):

<input type="checkbox"/> Patient is not pregnant (or a male with a pregnant female partner) and not planning to become pregnant during treatment
<input type="checkbox"/> Agreement that partners will use 2 forms of effective non-hormonal contraception during treatment (and for 6 months after therapy completion for those on ribavirin). Please list non-hormonal birth control options discussed with member _____
16. Is the member taking any of the following medications: amiodarone, rifampin, rifabutin, rifapentine, carbamazepine, eslicarbazepine, phenytoin, phenobarbital, oxcarbazepine, tipranavir/ritonavir, simeprevir, rosuvastatin, St. John's wort, or elvitegravir/cobicistat/emtricitabine in combination with tenofovir disoproxil fumarate?
Yes _____ No _____
17. Have all other clinically significant issues been addressed prior to starting therapy? Yes _____ No _____

Members must be adherent for continued approval. Treatment gaps of therapy longer than 3 days will result in denial of payment for subsequent requests for continued therapy. Refills must be prior authorized.

Prescriber Signature: _____ **Date:** _____

Has the member been counseled on appropriate use of Harvoni® therapy? Yes _____ No _____

Pharmacist Signature: _____ **Date:** _____

Please do not send in chart notes. Specific information/documentation will be requested if necessary. Failure to complete this form in full will result in processing delays. By signature, the prescriber or pharmacist confirms the above information is accurate.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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