

## Epclusa® Prior Authorization Request Form (Page 1 of 2)

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information <small>(required)</small>					
<b>Select the diagnosis below:</b> <input type="checkbox"/> Chronic Hepatitis C <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Clinical Information:</b> Document the patient's hepatitis C virus (HCV) genotype:* _____ Will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has a diagnosis of chronic hepatitis C virus?* <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please note: Chart documentation of the above is required to be submitted along with this fax.</i> Select if Epclusa is prescribed by or in consultation with one of the following: <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> HIV specialist <input type="checkbox"/> Hepatologist <input type="checkbox"/> Infectious disease specialist Will Epclusa be used with another HCV direct acting anti-viral agent [e.g., Sovaldi (sofosbuvir), Olysio (simeprevir)]? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have decompensated liver disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Will Epclusa be used in combination with ribavirin? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient ribavirin intolerant or ineligible? <input type="checkbox"/> Yes <input type="checkbox"/> No Will Epclusa be used alone (monotherapy)? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have prior failure (defined as viral relapse, breakthrough while on therapy, or non-responder therapy) to Sovaldi or NS5A-based treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient currently on Epclusa therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have history of failure, contraindication, or intolerance to Harvoni therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have history of failure, contraindication, or intolerance to Zepatier therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Quantity Limit Requests:</b> What is the quantity requested per DAY? _____ <b>What is the reason for exceeding the plan limitations?</b> <input type="checkbox"/> Titration or loading dose purposes <input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime) <input type="checkbox"/> Requested strength/dose is not commercially available <input type="checkbox"/> Other: _____					



1230 US Highway 11  
Gouverneur, NY 13642  
Phone: 1-877-635-9545

Prior Authorization Fax: 1-844-712-8129

## Epclusa® Prior Authorization Request Form (Page 2 of 2)

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.

**Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.**

**Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.**

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): \_\_\_\_\_ Date: \_\_\_\_\_

### PROACT INTERNAL USE ONLY:

#### Clinical Review Decision

Approved, through

Denied (documentation attached, if necessary)

#### Tracking:

1<sup>st</sup> Attempt

2<sup>nd</sup> Attempt

Letter Mailed:

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of ProAct. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

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