PRO ACT PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Harvoni® Prior Authorization Request Form (Page 1 of 2)

Member Information (required)			Provider Information (required)		
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 (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Chronic Hepatitis C virus (HCV)

❑ Other diagnosis:____________________ICD-10 Code(s): ____________________

Clinical Information:

Document the patient's HCV genotype*: ____________

Will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has a diagnosis of chronic hepatitis C genotype 1, 4, 5, or 6?* ❑ **Yes** ❑ **No**

**Please note: Chart documentation of the above is required to be submitted along with this fax.*

Select if Harvoni is prescribed by or in consultation with one of the following specialists:

❑ Gastroenterologist
❑ HIV specialist certified through the American Academy of HIV Medicine
❑ Hepatologist
❑ Infectious disease specialist

Is the patient a liver transplant recipient? ❑ **Yes** ❑ **No**

Does the patient have cirrhosis? ❑ **Yes** ❑ **No**

If "yes", will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has cirrhosis?* ❑ **Yes** ❑ **No**

Does the patient have decompensated liver disease (e.g., Child-Pugh Class B or C)? ❑ **Yes** ❑ **No**

Will Harvoni be used in combination with ribavirin? ❑ **Yes** ❑ **No**

If "no" to the above question, is the patient ribavirin ineligible? ❑ **Yes** ❑ **No**

Select the patient's treatment experience:

❑ Treatment naive
❑ Treatment failure with a previous treatment regimen that included Sovaldi (sofosbuvir) (except in combination with Olysio [simeprevir])
❑ Treatment failure with an NS5A inhibitor (e.g., Daklinza [daclatasvir])
❑ Treatment failure with a previous treatment regimen that included peginterferon plus ribavirin
❑ Treatment failure with an HCV protease inhibitor (e.g., Incivek [telaprevir], Olysio [simeprevir], Victrelis [boceprevir]) plus peginterferon plus ribavirin

Will the patient be receiving Harvoni in combination with another HCV direct activing antiviral agent [e.g., Sovaldi (sofosbu vir), Olysio (simeprevir)]? ❑ **Yes** ❑ **No**

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For genotype 1, also answer the following:

Will medical records (e.g., chart notes, laboratory values) be submitted documenting a pre-treatment HCV RNA level?* ❑ **Yes** ❑ **No**

Document the pre-treatment HCV RNA level:______________________________iU/mL Date: ______________________________

Please note: Chart documentation of the above is required to be submitted along with this fax.

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Harvoni® Prior Authorization Request Form (Page 2 of 2)

Quantity Limit Requests:
What is the quantity requested per DAY? _________
What is the reason for exceeding the plan limitations?
❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to tw o tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: ____

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

____

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:					
1st Attempt		2nd Attempt		Letter Mailed:	

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