NC Medicaid
Pharmacy Prior Approval Request for
Epclusa

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): ☐ 12 Weeks

Clinical Information

1. Is the beneficiary 3 years of age or older with a diagnosis of chronic hepatitis C (CHC) with genotype 1, 2, 3, 4, 5, or 6? ☐ **Yes** ☐ **No** **Genotype is: _____**
2. As the provider, are you reasonably certain that treatment will improve the beneficiary's overall health status?

   ☐ **Yes** ☐ **No**
3. Does the beneficiary have FDA-labeled contraindications to Epclusa? ☐ **Yes** ☐ **No**
4. Will Epclusa be used in combination with other drugs containing sofosbuvir? ☐ **Yes** ☐ **No**
5. Has the beneficiary tried and failed 2 preferred medications in this class or has a reason or contraindication to the preferred medications in the class? ☐ **Yes** ☐ **No** Please list t/f medications and/or any contraindications to the preferred medications:

   _____
   _____
   _____
   _____
   _____
   _____

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 CSRA at (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505

DHB Pharmacy 30
10.20.2023