WellCare

NC Medicaid

Pharmacy Prior Approval Request for

Harvoni Tablet/Pellet Pack/Ledipasvir-Sofosbuvir: PA Request Form

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. 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 Harvoni? ☐ **Yes** ☐ **No**
4. Will Harvoni 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 does the beneficiary have 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

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