



**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 (800) 678-3189

Pharmacy PA Call Center: (866) 799-5318