ProCare Rx

Epclusa®

Ticket #: ____________________ Request Date: ______________________ Request Time: ______________________

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

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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

❑ Other diagnosis: ____________________________________ ICD-10 Code(s): ________________________________

Clinical Information:

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?* ❑ **Yes** ❑ **No**

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

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

❑ Gastroenterologist ❑ HIV specialist

❑ Hepatologist ❑ Infectious disease specialist

Will Epclusa be used with another HCV direct acting anti-viral agent [e.g., Sovaldi (sofosbuvir), Olysio (simeprevir)]? ❑ **Yes** ❑ **No**

Does the patient have decompensated liver disease? ❑ **Yes** ❑ **No**

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

Is the patient ribavirin intolerant or ineligible? ❑ **Yes** ❑ **No**

Will Epclusa be used alone (monotherapy)? ❑ **Yes** ❑ **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? ❑ **Yes** ❑ **No**

Is the patient currently on Epclusa therapy? ❑ **Yes** ❑ **No**

Does the patient have history of failure, contraindication, or intolerance to Harvoni therapy? ❑ **Yes** ❑ **No**

Does the patient have history of failure, contraindication, or intolerance to Zepatier therapy? ❑ **Yes** ❑ **No**

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 two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other: ____

Please note that this form is to be completed by the prescribing physician. 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. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). 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.**

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

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

____

____

Authorized Medical Signature:	
Telephone:	Date:

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

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

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