

Ticket #: _____ Request Date: _____ Request Time: _____

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

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information <small>(required)</small>					
Select the diagnosis below: <input type="checkbox"/> Chronic hepatitis C (CHC) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information: Will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has a diagnosis of chronic hepatitis C genotype 4? * <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please note: Chart documentation of the above is required to be submitted along with this fax.</i> Does the patient have compensated liver disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have cirrhosis? <input type="checkbox"/> Yes <input type="checkbox"/> No Will Technivie be used in combination with ribavirin? <input type="checkbox"/> Yes <input type="checkbox"/> No If "no", does the patient have history of intolerance or contraindication to ribavirin? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient treatment naïve? <input type="checkbox"/> Yes <input type="checkbox"/> No Select if Technivie is prescribed by or in consultation with one of the following specialists: <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> HIV specialist certified through the American Academy of HIV Medicine <input type="checkbox"/> Hepatologist <input type="checkbox"/> Infectious disease specialist Will the patient be receiving Technivie in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir-sofosbuvir), Sovaldi (sofosbuvir), Olysio (simeprevir)]? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have moderate to severe hepatic impairment (e.g., Child-Pugh B or C)? <input type="checkbox"/> Yes <input type="checkbox"/> No Select if the patient has history of intolerance or contraindication to the following: <input type="checkbox"/> Harvoni <input type="checkbox"/> Zepatier Is this request for continuation of prior Technivie therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Quantity Limit Requests: What is the quantity requested per TREATMENT? _____ (number of tablets) for _____ days (treatment duration) What is the reason for exceeding the plan limitations? <input type="checkbox"/> Titration or loading dose purposes <input type="checkbox"/> 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) <input type="checkbox"/> Requested strength/dose is not commercially available <input type="checkbox"/> 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.
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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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