



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit [go.covermymeds.com/OptumRx](http://go.covermymeds.com/OptumRx) to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

## Daklinza™ Prior Authorization Request Form (Page 1 of 2)

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

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 <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information <small>(required)</small>					
<b>Select the diagnosis below:</b>					
<input type="checkbox"/> Chronic hepatitis C virus (HCV)					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Clinical Information:</b>					
Document the patient's HCV genotype:* _____					
Will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has a diagnosis of HCV genotype 1 or 3 infection?* <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>					
<i>*Please note: Chart documentation of the above is required to be submitted along with this fax.</i>					
Does the patient have decompensated liver disease? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>					
Does the patient have cirrhosis? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>					
Is the patient a liver transplant recipient? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>					
Select if Daklinza will be used in combination with the following:					
<input type="checkbox"/> Sovaldi					
<input type="checkbox"/> Ribavirin					
Select if Daklinza 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			
Has the patient failed a prior HCV NS5A-containing regimen (e.g., Daklinza)? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>					
Select if the patient has had trial and failure, contraindication, or intolerance to the following, if applicable for the patient's genotype:					
<input type="checkbox"/> Epclusa (sofosbuvir/velpatasvir)					
<input type="checkbox"/> Harvoni (ledipasvir/sofosbuvir)					
<input type="checkbox"/> Mavyret (glecaprevir/pibrentasvir)					
Is this request for continuation of prior Daklinza plus Sovaldi therapy? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>					
<b>Quantity Limit Requests:</b>					
What is the quantity requested per DAY? _____					
<b>What is the reason for exceeding the plan limitations?</b>					
<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: _____					

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. The information in this document is for the sole use of OptumRx. 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.**

Office use only: Daklinza\_Comm\_2019Mar-W



## Daklinza™ 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?

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Please note:

This request may be denied unless all required information is received.  
For urgent or expedited requests please call 1-800-711-4555.  
This form may be used for non-urgent requests and faxed to 1-800-527-0531.