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

Harvoni® & ledipasvir/sofosbuvir 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)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
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 virus (HCV)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Document the patient's HCV genotype:* _____

Will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has a diagnosis of chronic hepatitis C genotype 1, 4, 5, or 6?* ❑ **Yes** ❑ **No**

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

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

- ❑ Gastroenterologist
- ❑ Hepatologist
- ❑ HIV specialist certified through the American Academy of HIV Medicine
- ❑ Infectious disease specialist

Is the patient a liver transplant recipient? ❑ **Yes** ❑ **No**

Does the patient have cirrhosis? ❑ **Yes** ❑ **No**

If "yes", will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has cirrhosis?* ❑ **Yes** ❑ **No**

Does the patient have decompensated liver disease (e.g., Child-Pugh Class B or C)? ❑ **Yes** ❑ **No**

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

If "no" to the above question, is the patient ribavirin ineligible? ❑ **Yes** ❑ **No**

Select the patient's treatment experience:

- ❑ Treatment naive
- ❑ Treatment failure with a previous treatment regimen that included Sovaldi (sofosbuvir) (except in combination with Olysio [simeprevir])
- ❑ Treatment failure with an NS5A inhibitor (e.g., Daklinza [daclatasvir])
- ❑ Treatment failure with a previous treatment regimen that included peginterferon plus ribavirin
- ❑ Treatment failure with an HCV protease inhibitor (e.g., Incivek [telaprevir], Olysio [simeprevir], Victrelis [boceprevir]) plus peginterferon plus ribavirin

Will the patient be receiving Harvoni in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir), Olysio (simeprevir)]? ❑ **Yes** ❑ **No**

For generic ledipasvir/sofosbuvir requests: Has the patient had trial and failure or intolerance to Brand Harvoni, unless the patient is already receiving generic ledipasvir/sofosbuvir therapy? ❑ **Yes** ❑ **No**

Harvoni® & ledipasvir/sofosbuvir Prior Authorization Request Form (Page 2 of 2)

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For genotype 1, also answer the following:

Will medical records (e.g., chart notes, laboratory values) be submitted documenting a pre-treatment HCV RNA level?* ❑ **Yes** ❑ **No**

Document the pre-treatment HCV RNA level: _____ iU/mL Date: _____

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

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: _____

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

_____

_____

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.