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

Technivie® 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 (CHC)

❑ 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?* ❑ **Yes** ❑ **No**

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

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

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

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

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

❑ Gastroenterologist ❑ HIV specialist certified through the American Academy of HIV Medicine

❑ Hepatologist ❑ 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)]? ❑ **Yes** ❑ **No**

Does the patient have moderate to severe hepatic impairment (e.g., Child-Pugh B or C)? ❑ **Yes** ❑ **No**

Select if the patient has had a trial and failure, intolerance or contraindication to the following:

❑ Epclusa (sofosbuvir/velpatasvir)

❑ Harvoni (ledipasvir/sofosbuvir)

❑ Mavyret (glecaprevir/pibrentasvir)

Is this request for continuation of prior Technivie therapy? ❑ **Yes** ❑ **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?

❑ 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: _____

Technivie® 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?

_____

_____

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.