



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

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 (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:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
<input type="checkbox"/> Chronic hepatitis C virus (HCV)					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information:					
Document the patient's HCV genotype: _____					
Will Daklinza be used in combination with Sovaldi (sofosbuvir)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Will Daklinza be used in combination with ribavirin? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Select if Daklinza is prescribed by or in consultation with one of the following specialists:					
<input type="checkbox"/> Gastroenterologist					
<input type="checkbox"/> Hepatologist					
<input type="checkbox"/> HIV specialist certified through the American Academy of HIV Medicine					
<input type="checkbox"/> Infectious disease specialist					
If the patient requires Daklinza 90mg a day, will the patient concomitantly receive a moderate CYP3A inducer (e.g., bosentan, dexamethasone, efavirenz, etravirine, modafinil)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient failed a prior HCV NS5A-containing regimen (e.g., Daklinza)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If "yes" to the above question, will medical records (e.g., chart notes) be submitted documenting the patient does not have NS5A inhibitor resistance-associated variants detected using commercially available assays?* <input type="checkbox"/> Yes <input type="checkbox"/> No					
*Please note: Chart documentation of the above is required to be submitted along with this fax.					
Is the patient currently on Daklinza (daclatasvir) therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
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)					
Does the patient have cirrhosis? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have decompensated liver disease (Child-Pugh Class B or C)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the patient a liver-transplant recipient? <input type="checkbox"/> Yes <input type="checkbox"/> No					

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_CMS_2019Feb-W



Daklinza™ Prior Authorization Request Form (Page 2 of 2)
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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
- There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify:** _____
- 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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.