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

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

Epclusa® Prior Authorization Request Form

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 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 virus	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
Clinical Information:	
Document the patient's hepatitis C virus (HCV) genotype: _____	
Will Epclusa (sofosbuvir/velpatasvir) be used in combination with another HCV direct acting anti-viral agent [e.g., Sovaldi (sofosbuvir)]? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the patient have decompensated liver disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will Epclusa be used alone? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will Epclusa be used in combination with ribavirin? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the patient have intolerance or is ineligible to ribavirin therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Select if Epclusa 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
Does the patient have prior failure (defined as viral relapse, breakthrough while on therapy, or non-responder to therapy) to Sovaldi or NS5A-based treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Quantity limit requests:	
What is the quantity requested per DAY? _____	
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"/> 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: _____	
<input type="checkbox"/> 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.

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: Epclusa_CMS_2019Jan-W