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

Viekira Pak® & Viekira XR™ 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: _____

Select if Viekira 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

Has the patient experienced prior failure with an NS5A inhibitor or NS3/4A protease inhibitor-containing regimen? ❑ **Yes** ❑ **No**

If "yes" to the above question, does the patient have NS3 protease inhibitor or NS5A inhibitor resistance-associated variants detected using commercially available assays? ❑ **Yes** ❑ **No**

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

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

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

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

If "yes" to the above question, does the patient have normal hepatic function and mild fibrosis (e.g., METAVIR fibrosis score less than or equal to F2)? ❑ **Yes** ❑ **No**

Document hepatic function and fibrosis stage: _____

Will Viekira be used in combination with another HCV direct acting anti-viral agent [e.g., Harvoni (ledipasvir-sofosbuvir), Sovaldi (sofosbuvir)]? ❑ **Yes** ❑ **No**

Is this request for continuation of prior Viekira therapy? ❑ **Yes** ❑ **No**

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

- ❑ Epclusa, sofosbuvir/velpatasvir
- ❑ Harvoni, ledipasvir/sofosbuvir
- ❑ Mavyret (glecaprevir/pibrentasvir)
- ❑ Vosevi (sofosbuvir/velpatasvir/voxilaprevir)
- ❑ Zepatier (elbasvir/grazoprevir)

Viekira Pak® & Viekira XR™ Prior Authorization Request Form (Page 2 of 2)

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Quantity Limit:

What is the quantity requested per MONTH? _____

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.