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

Zepatier® 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:
❑ 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 Zepatier 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 use Zepatier in combination with ribavirin? ❑ **Yes** ❑ **No**

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

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

❑ Epclusa, sofosbuvir/velpatasvir ❑ Mavyret (glecaprevir/pibrentasvir)

❑ Harvoni, ledipasvir/sofosbuvir ❑ Vosevi (sofosbuvir/velpatasvir/voxilaprevir)

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

For genotype 1, also answer the following:

Select the patient's treatment experience:

❑ Treatment-naive

❑ Prior failure to peginterferon alfa plus ribavirin treatment

❑ Prior failure to treatment with peginterferon alfa plus ribavirin plus a HCV NS3/4A protease inhibitor (e.g., boceprevir, simeprevir, or telaprevir)

Has the patient been tested for the presence of NS5A resistance-associated polymorphisms? ❑ **Yes** ❑ **No**

If "yes" to the above question, does the patient have baseline NS5A resistance-associated polymorphisms (i.e., polymorphisms at amino acid positions 28, 30, 31, or 93)? ❑ **Yes** ❑ **No**

For genotype 4, also answer the following:

Is the patient treatment-naïve? ❑ **Yes** ❑ **No**

Has the patient experienced prior viral relapse with peginterferon alfa plus ribavirin treatment? ❑ **Yes** ❑ **No**

Has the patient had prior on-treatment virologic failure (failure to suppress or viral breakthrough) to peginterferon alfa plus ribavirin treatment? ❑ **Yes** ❑ **No**

Zepatier® 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.