

Ticket #: _____ Request Date: _____ Request Time: _____

Epclusa® Prior Authorization Request Form (Page 1 of 2)
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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					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information:					
Document the patient's hepatitis C virus (HCV) genotype:* _____					
Will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has a diagnosis of chronic hepatitis C virus?* <input type="checkbox"/> Yes <input type="checkbox"/> No					
<i>*Please note: Chart documentation of the above is required to be submitted along with this fax.</i>					
Select if Epclusa is prescribed by or in consultation with one of the following:					
<input type="checkbox"/> Gastroenterologist		<input type="checkbox"/> HIV specialist			
<input type="checkbox"/> Hepatologist		<input type="checkbox"/> Infectious disease specialist			
Will Epclusa be used with another HCV direct acting anti-viral agent [e.g., Sovaldi (sofosbuvir), Olysio (simeprevir)]? <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 in combination with ribavirin? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the patient ribavirin intolerant or ineligible? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Will Epclusa be used alone (monotherapy)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have prior failure (defined as viral relapse, breakthrough while on therapy, or non-responder therapy) to Sovaldi or NS5A-based treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the patient currently on Epclusa therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have history of failure, contraindication, or intolerance to Harvoni therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have history of failure, contraindication, or intolerance to Zepatier therapy? <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"/> Other: _____					

Please note that this form is to be completed by the prescribing physician. 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. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). 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_Comm_5/2019

Epclusa® 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?

Authorized Medical Signature:	
Telephone:	Date:

When Completed Return To:

MC-Rx Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

Please note: This request may be denied unless all required information is received.