SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Harvoni® (Ledipasvir/Sofosbuvir) Initiation Interim Prior Authorization Form

Member Name: _____ ***Date of Birth:***_____ ***Member ID#:***_____
Pharmacy NPI:_____ ***Pharmacy Phone:*** _____ ***Pharmacy Fax:***_____
Pharmacy Name:_____ ***Pharmacist Name:***_____
Prescriber NPI: _____ ***Prescriber Name:*** _____ ***Specialty:*** _____
Prescriber Phone:_____ ***Prescriber Fax:*** _____ ***Drug Name:*** _____
NDC:_____ ***Start Date:***_____

Clinical Information

1. HCV Genotype (including subtype): _____ Date Determined: _____
2. METAVIR Equivalent Fibrosis Stage:_____ Testing Type:_____
   Date Fibrosis Stage Determined:_____
3. Pre-treatment viral load in the last 12 months (must be within last 3 months if requesting 8-week regimen):
   Pre-treatment viral load: _____ Date Taken: _____
   For METAVIR score of <F1, 2nd test must confirm chronic HCV diagnosis at least 6 months after 1st test.
   Prior pre-treatment viral load or antibody test: _____ Date Taken:_____
4. Does member have decompensated hepatic disease (CTP class B or C)? Yes___ No___
5. Is the member currently on hospice or does the member have a limited life expectancy (less than 12 months) that cannot be remediated by treating HCV? Yes____ No____
6. Does the member have severe renal impairment (estimated eGFR <30mL/min/m^2 ? Yes____ No___
7. Has the member been evaluated by a gastroenterologist, infectious disease specialist, or a transplant specialist within the past 3 months? Yes___ No___
8. If yes, please include name of specialist recommending hepatitis C treatment: _____
9. Has the member been previously treated for hepatitis C? Yes___ No___
10. If yes, please indicate previous treatment regimen and reason for failure (relapser, null-responder, partial responder): _____
11. Please indicate requested regimen below:
    - ❑ Harvoni® 90mg/400mg daily x 56 days (8 weeks)
    - ❑ Harvoni® 90mg/400mg daily x 84 days (12 weeks)
    - ❑ Harvoni® 90mg/400mg daily with weight-based ribavirin x 84 days (12 weeks)
    - ❑ Other:_____
12. Has the member signed the intent to treat contract**? Yes___ No___ ***Required for processing of request*
13. Has the member been counseled on the harms of illicit IV drug use and alcohol use and agreed to not use illicit IV drugs or alcohol while on or after they finish hepatitis C treatment? Yes____ No____
14. Has the member initiated immunization with the hepatitis A and B vaccines? Yes___ No___
15. For women of childbearing potential (and male patients with female partners of childbearing potential):
    - ❑ Patient is not pregnant (or a male with a pregnant female partner) and not planning to become pregnant during treatment
    - ❑ Agreement that partners will use two forms of effective non-hormonal contraception during treatment (and for six months after therapy completion for those on ribavirin). Please list non-hormonal birth control options discussed with member_____
16. Is the member taking any of the following medications: amiodarone, rifampin, rifabutin, rifapentine, carbamazepine, eslicarbazepine, phenytoin, phenobarbital, oxcarbazepine, tipranavir/ritonavir, simeprevir, rosuvastatin, St. John's wort, or elvitegravir/cobicstat/emtricitabine in combination with tenofovir disoproxil fumarate?
    Yes___ No___
17. Have all other clinically significant issues been addressed prior to starting therapy? Yes___ No___

❑ This patient is in need of additional support. I recommend this patient be followed by an OHCA Care Management Nurse.

Members must be adherent for continued approval. Treatment gaps of therapy longer than 3 days will result in denial of payment for subsequent requests for continued therapy. Refills must be prior authorized.

Prescriber Signature: _____ **Date:** _____

Has the member been counseled on appropriate use of Harvoni® therapy? Yes___ No___

Pharmacist Signature: _____ **Date:** _____

Please do not send in chart notes. Specific information/documentation will be requested if necessary. Failure to complete this form in full will result in processing delays. By signature, the prescriber or pharmacist confirms the above information is accurate.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*