PRIOR AUTHORIZATION REQUEST FORM

Medicare Part D - Harvoni

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note, any information left blank or illegible may delay the review process.

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What is the patient's diagnosis?

- ☐ Genotype 1a chronic HCV (or MIXED genotype 1a and 1b)
- ☐ Genotype 1b chronic HCV
- ☐ Genotype 2 chronic HCV
- ☐ Genotype 3 chronic HCV
- ☐ Genotype 4 chronic HCV
- ☐ Genotype 5 chronic HCV
- ☐ Genotpye 6 chronic HCV
- ☐ Other (please specify)

Q2. Please provide ICD code(s) for diagnosis

Q3. Select the requested drug and regimen.

- ☐ Harvoni x 8 weeks
- ☐ Harvoni x 12 weeks

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☐ Harvoni x 24 weeks
☐ Harvoni and Ribavirin x 12 weeks
☐ Other [specify drug name(s), strength(s), regimen, duration]

Q4. Specify the prescriber's specialty.
☐ Hepatologist
☐ Board Certified Infectious Disease specialist
☐ Board Certified Gastroenterologist
☐ Other (please specify)

Q5. Is the patient greater than or equal to 18 years of age?
☐ Yes ☐ No

Q6. What is the patient's baseline HCV RNA viral load?

Q7. Select the status that applies to this patient and provide documentation to support selection.
☐ Clinically DECOMPENSATED cirrhosis
☐ Compensated cirrhosis
☐ No evidence of cirrhosis

Q8. Describe the patient's previous treatment history.
☐ Never been treated
☐ Relapsed
☐ Partial responder
☐ Null responder
☐ Treated but did not complete full course of therapy

Q9. Describe the patient's previous treatment history and include DRUG NAMES, DATES OF TREATMENT, LENGTH OF TREATMENT, OUTCOME / RESPONSE.

Q10. Has the patient had a liver transplant?

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☐ Yes ☐ No	
Q11. Additional Comments:	

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function