

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

Viekira Pak® & Viekira XR® 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:

Chronic hepatitis C

Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Document the patient's HCV genotype:* _____

Will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has a diagnosis of chronic hepatitis C genotype 1a, 1b or mixed genotype 1 infection?* Yes No

Does the patient have cirrhosis?* Yes No

If "yes", will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has cirrhosis?* Yes No

If "no", will medical records be submitted documenting the patient has normal hepatic function and mild fibrosis (e.g., METAVIR fibrosis score less than or equal to F2)?* Yes No

**Please note: Chart documentation of the above is required to be submitted along with this fax.*

Is the patient a liver transplant recipient? 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

Has the patient experienced failure with a previous treatment regimen that includes a HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] or an NS5A inhibitor [Daklinza (daclatasvir)]? Yes No

Is the patient receiving Viekira in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir-sofosbuvir), Sovaldi (sofosbuvir), Olysio (simeprevir)]? Yes No

Has the patient had a **trial and failure, contraindication or intolerance** to Harvoni therapy? Yes No

Has the patient had a **trial and failure, contraindication or intolerance** to Zepatier therapy? Yes No

Is the patient currently on Viekira Pak/Viekira XR therapy? Yes No

Select if Viekira 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

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: Viekira_Comm_2017Dec

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

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Quantity Limit Requests:

What is the quantity requested per DAY? _____

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
- 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?

Authorized Medical Signature: _____

Telephone: _____

Date: _____

When Completed Return To:

ProCare PBM 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.