ProCare Rx

Viekira Pak® & Viekira XR®

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

Viekira Pak® & Viekira XR® 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)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
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

❑ 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

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.