

Prior Authorization Form

HEPATITIS C AGENTS (FA-PA)

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS Caremark at **1-888-836-0730**. Please contact CVS Caremark at **1-855-240-0536** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Olysio (simeprevir).

Patient Information

Patient Name:	<input type="text"/>
Patient Phone:	<input type="text"/>
Patient ID:	<input type="text"/>
Patient Group No:	<input type="text"/>
Patient DOB:	<input type="text"/>

Prescribing Physician

Physician Name:	<input type="text"/>
Physician Phone:	<input type="text"/>
Physician Fax:	<input type="text"/>
Physician Address:	<input type="text"/>
City, State, Zip:	<input type="text"/>

Drug Name (specify drug): Olysio (simeprevir)

Quantity:	<input type="text"/>	Frequency:	<input type="text"/>	Strength:	<input type="text"/>
Route of Administration:	<input type="text"/>	Expected Length of Therapy:	<input type="text"/>		
Diagnosis:	<input type="text"/>	ICD Code:	<input type="text"/>		
Comments:	<input type="text"/>				

Please check the appropriate answer for each applicable question.

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|-----|--|---|--------------------------|---|--------------------------|
| 1. | Is the requested drug being prescribed for treatment of chronic hepatitis C infection? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 2. | Is the patient currently receiving treatment with the requested drug? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 3. | Does the patient have genotype 1, 4, 5, or 6 infection? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 4. | The preferred product for your patient's plan is Harvoni.
Can the patient's treatment be switched to Harvoni? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 5. | Has the patient had an inadequate virologic response to a previous trial of Harvoni? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 6. | Is the requested drug any of the following: Viekira Pak, Viekira XR, or Zepatier? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 7. | Does the patient have end-stage renal disease (ESRD) or creatinine clearance (CrCl) of less than 30 mL/min? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 8. | Does the patient have genotype 2 or 3 infection? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 9. | The preferred product for your patient's plan is Epclusa.
Can the patient's treatment be switched to Epclusa? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 10. | Has the patient had an inadequate virologic response to a previous trial of Epclusa? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the claims processor, the health

plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733.

Prescriber (Or Authorized) Signature and Date

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