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 Technivie (ombitasvir-paritaprevir-ritonavir).

Patient Information

Patient Name:

Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐

Patient ID:

Patient Group No:

Patient DOB: ☐☐/☐☐/☐☐☐☐

Prescribing Physician

Physician Name:

Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐

Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐

Physician Address:

City, State, Zip:

Drug Name (specify drug): Technivie (ombitasvir-paritaprevir-ritonavir)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

_____

Please check the appropriate answer for each applicable question.

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

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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