SoonerCare
Oklahoma Health Care Authority

# State of Oklahoma
# Oklahoma Health Care Authority
# Harvoni® (Ledipasvir/Sofosbuvir) Initiation Prior Authorization Form

***Member Name:*** _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

***Pharmacy NPI:*** _____ ***Pharmacy Phone:*** _____ ***Pharmacy Fax:*** _____

***Pharmacy Name:*** _____ ***Pharmacist Name:*** _____

***Prescriber NPI:*** _____ ***Prescriber Name:*** _____ ***Specialty:*** _____

***Prescriber Phone:*** _____ ***Prescriber Fax:*** _____ ***Drug Name:*** _____

***NDC:*** _____ ***Start Date:*** _____

## Clinical Information

1. Diagnosis: _____ HCV Genotype (including subtype): _____
2. METAVIR Fibrosis Stage: _____ Date Determined: _____
3. Pre-Treatment Viral Load (HCV RNA): _____ Date Determined: _____
4. Does member have decompensated hepatic disease (CTP class B or C)? Yes ___ No ___
5. Does member have severe renal impairment (estimated eGFR <30mL/min/$m^2$? Yes ___ No ___
6. Has the member been evaluated by a gastroenterologist, infectious disease specialist, or a transplant specialist within the past 3 months? Yes ___ No ___
7. If yes, please include name of specialist recommending hepatitis C treatment: _____
8. Has the member been previously treated for hepatitis C? Yes ___ No ___
9. If yes, please indicate previous treatment regimen and reason for failure: _____
   _____
10. Please indicate requested regimen below:
    - ❑ Harvoni® 90mg/400mg daily x 56 days (8 weeks)
    - ❑ Harvoni® 90mg/400mg daily x 84 days (12 weeks)
    - ❑ Harvoni® 90mg/400mg daily x 168 days (24 weeks)
    - ❑ Other: _____ **

    ***Please supply reference citation to support requested therapy.*
11. Has the member signed the intent to treat contract**? Yes ___ No ___

    ***Required for processing of prior authorization request*
12. Has the member had illicit IV drug use or alcohol abuse in the last 6 months? Yes ___ No ___
13. Has the member initiated immunization with the hepatitis A and B vaccines? Yes ___ No ___
14. For women of childbearing potential (and male patients with female partners of childbearing potential):
    - ❑ Patient is not pregnant (or a male with a pregnant female partner) and not planning to become pregnant during treatment
    - ❑ Agreement that partners will use two forms of effective non-hormonal contraception during treatment

      Please list non-hormonal birth control options discussed with member _____
15. Is the member taking any of the following medications: amiodarone, rifampin, rifabutin, rifapentine, carbamazepine, eslicarbazepine, phenytoin, phenobarbital, oxcarbazepine, tipranavir/ritonavir, simeprevir, rosuvastatin, St. John's wort, or elvitegravir/cobicstat/emtricitabine in combination with tenofovir disoproxil fumarate? Yes ___ No ___
16. Have all other clinically significant issues been addressed prior to starting therapy? Yes ___ No ___

❑ I recommend this patient be followed by an OHCA Care Management Nurse.

***Members must be adherent for continued approval. Treatment gaps of therapy longer than 3 days will result in denial of payment for subsequent requests for continued therapy. Refills must be prior authorized.***

**Prescriber Signature:** _____ **Date:** _____

Has the member been counseled on appropriate use of Harvoni® therapy? Yes ___ No ___

**Pharmacist Signature:** _____ **Date:** _____

*Please do not send in chart notes. Specific information/documentation will be requested if necessary.*

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

CONFIDENTIALITY NOTICE