

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: Medicare Part B Medicare Part D
 This request is: Expedited request Standard request

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Harvoni[®] (ledipasvir /sofosbuvir)

Member

Last Name: _____ First Name: _____
 ID #: _____ DOB: _____ Gender: _____
 Primary Care Physician: _____
 Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____
 Provider Address: _____
 Provider NPI: _____ Contact Name: _____
 Provider Signature: _____ Date: _____

What is the provider's specialty?
 Gastroenterologist Hepatologist Infectious disease specialist Other: _____

Product Information

New request Continuation request
 Drug product: Harvoni 90mg-400mg tablet **Start date** (or date of next dose): _____
Date of last dose (if applicable): _____
 Requested Duration: 12 weeks 24 weeks Other _____

Precertification Requirements

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

1. Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist
2. Must be age 12 or older
3. Must have a diagnosis of chronic hepatitis C infection

Additional information

Note: Criteria (including criteria for duration of approval) will be applied consistent with current AASLD/IDSA (American Association for the Study of Liver Disease/Infectious Disease Society of America) guidelines

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — or — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- Chronic hepatitis C infection
 Other – the patient’s condition is: _____

B. What is the patient’s HCV genotype?

- 1a 1b 2 3 4 5 6

C. Has the patient previously received treatment for chronic hepatitis C?

- Yes, the drug(s) used were: _____
 No

D. Does the patient have liver cirrhosis?

- Yes
 Compensated
 Decompensated
 No

E. Has the patient had a liver transplant?

- Yes No

F. What is the patient’s current pre-treatment HCV RNA? _____ IU/mL

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? Yes No
 If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Harvoni likely be the most effective option for this patient?

Yes No
 If yes, please explain why: _____

If the patient is currently using Harvoni, would changing the patient’s current regimen likely result in adverse effects for the patient?

Yes No
 If yes, please explain: _____

