

## Harvoni (ledipasvir; sofosbuvir) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

			URGEN	
MEMBER INFORMATION				
LAST NAME:		FIRST NAME:		
PHONE NUMBER:		DATE OF BIRTH:	DATE OF BIRTH:	
STREET ADDRESS:				
CITY:		STATE: ZIP CO	DDE:	
PATIENT INSURANCE ID	NUMBER:			
MALE FEMALE	HEIGHT (IN/CM): W	EIGHT (LB/KG): ALLE	ERGIES:	
		DISCLOSURE AUTHORIZATION FORM WITH THI OMMON/DOC/EN-US/PHI_DISCLOSURE_AUTH		
		BLE):		
PRESCRIBER INFORMATI	ON			
LAST NAME:		FIRST NAME:	FIRST NAME:	
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:	EMAIL ADDRESS:	
NPI NUMBER:		DEA NUMBER:		
PHONE NUMBER:		FAX NUMBER:	FAX NUMBER:	
STREET ADDRESS:				
CITY:		STATE: ZIP CO	DDE:	
REQUESTOR (if different than prescriber):		OFFICE CONTACT PERSO	OFFICE CONTACT PERSON:	
		1		
MEDICATION OR MEDIC	AL DISPENSING INFORMATIO	N		
MEDICATION NAME:				
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:	
□ NEW THERAPY       □ RENEWAL         DURATION OF THERAPY (SPECIFIC DATES):		IF RENEWAL: DATE THER	IF RENEWAL: DATE THERAPY INITIATED:	
Continued on next page.				

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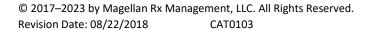


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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:		
1. HAS THE PATIENT TRIED ANY OTHE	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO	
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	<b>DURATION OF THERAPY</b> (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:	
BROWN WILL FILLD BOSK GETT	Sixtes).	THE STEP NEED TO	
2. LIST DIAGNOSES:		ICD-10:	
☐ Chronic hepatitis C virus			
☐ Other Diagnosis ICD-10 C			
<b>3. REQUIRED CLINICAL INFORMATION</b> PRIOR AUTHORIZATION.	: PLEASE PROVIDE ALL RELEVANT CLINIC	AL INFORMATION TO SUPPORT A	
Clinical Information:			
Is this a request for re-treatment w itl	h Harvoni?* □ Yes □ No		
*If "yes," please submit patient chart	notes with clinical rationale explaining	why re-treatment is necessary.	
Does the patient have severe renal im (ESRD)? ☐ Yes ☐ No	pairment (eGFR less than 30 mL/min/1.	73 m2) or end-stage renal disease	
Is Harvoni prescribed by a hepatologis	st, gastroenterologist, or infectious disea	ase specialist?   Yes   No	
Document the patient's chronic hepat *Please provide supporting lab report			
Trouble provide supporting tax report	-		
Is the patient a liver transplant recipie	ent? 🗆 Yes 🗆 No		
Does the patient have cirrhosis?   Yes	s □ No		
Does the patient have decompensate	d liver disease (Child-Pugh class B or C)?	□ Yes □ No	
Will Harvoni be used in combination v	with ribavirin?    Yes □ No		
Select if the patient's treatment expense	rience:		
☐ Treatment-naive			
☐ Previous treatment with peginterfe	•		
	ron plus ribavirin plus an HCV protease i	nhibitor	
☐ Previous treatment with sofosbuvir	-based regimen		
Are there any other comments, diagn physician feels is important to this rev	oses, symptoms, medications tried or fa view?	iled, and/or any other information the	
Please note: Not all drugs/diagnosis as	to covered on all plans. This request may	ho donied unloss all required	
information is received.	e covered on all plans. This request may	be defiled diffess all required	







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**ATTESTATION:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

## **Prescriber Signature or Electronic I.D. Verification:**

Date:

**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**FAX THIS FORM TO: 800-424-7640** 

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP - 4201 P.O. Box 64811 St. Paul, MN 55164-0811

