

Ticket #: _____ Request Date: _____ Request Time: _____

Olysio® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Chronic Hepatitis C virus (HCV)	
<input type="checkbox"/> Other diagnosis: _____	ICD-10 Code(s): _____

Clinical Information:
 Document the patient's HCV genotype*: _____
 Will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has a diagnosis of chronic hepatitis C genotype 1a, 1b, or 4? **Yes** **No**
 For genotype 1a, does the patient have the NS3 Q80K polymorphism? **Yes** **No**
**Please note: Chart documentation of the above is required to be submitted along with this fax.*
 Has the patient experienced failure with a previous treatment regimen that includes Olysio or other HCV NS3/4A protease inhibitors [e.g., Incivek (telaprevir), Victrelis (boceprevir)]? **Yes** **No**
 Does the patient have decompensated liver disease (e.g., Child-Pugh Class B or C)? **Yes** **No**
 Does the patient have cirrhosis? **Yes** **No**
 If "yes", will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has cirrhosis? **Yes** **No**
**Please note: Chart documentation of the above is required to be submitted along with this fax.*
 Will Olysio be used in combination with peginterferon alfa and ribavirin? **Yes** **No**
 Will Olysio be used in combination with Sovaldi (sofosbuvir)? **Yes** **No**
 Select if Olysio is prescribed by or in consultation with one of the following specialists:
 Gastroenterologist HIV specialist certified through the American Academy of HIV Medicine
 Hepatologist Infectious disease specialist
 Is this request for continuation of prior Olysio therapy? **Yes** **No**
 Has the patient had trial and failure, contraindication, or intolerance to Harvoni therapy? **Yes** **No**
 Has the patient had trial and failure, contraindication, or intolerance to Zepatier therapy? **Yes** **No**
 Does the patient have NS5A inhibitor resistant-associated variants as confirmed by commercially available assays? **Yes** **No**

Quantity Limit Requests: What is the quantity requested per DAY? _____
What is the reason for exceeding the plan limitations?
<input type="checkbox"/> Titration or loading dose purposes
<input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
<input type="checkbox"/> Requested strength/dose is not commercially available
<input type="checkbox"/> Other: _____

Please note that this form is to be completed by the prescribing physician. This document and others, if attached, contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately.
 Office use only: Olysio_Comm_5/2019

Olysio® Prior Authorization Request Form (Page 2 of 2)
DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Authorized Medical Signature:	
Telephone:	Date:

When Completed Return To:

MC-Rx Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

Please note: This request may be denied unless all required information is received.