Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information	
Requested Drug(s) & Strength(s):	[ ] sofosbuvir 400 mg-velpatasvir 100 mg tablet
Requested Quantity Limit Over Time – Amount:	
Requested Quantity Limit Over Time – Days:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year)) _____ (*Required)

[ ] No

Q3: What is the member's diagnosis? (Check only one that apply)

[ ] Chronic hepatitis C infection

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q4: Is the request for one of the following? (Check only one that apply)

[ ] Chronic Hepatitis C (without decompensation) - Genotype 1, 2, 3, 4, 5, or 6

[ ] Chronic Hepatitis C - Genotype 1, 2, 3, 4, 5, or 6 - Patients with Decompensated Liver Disease - Epclusa plus ribavirin

[ ] Chronic Hepatitis C - Genotype 1, 2, 3, 4, 5, or 6 - Patients with Decompensated Liver Disease - Ribavirin Intolerance/Ineligible OR Prior Sofosbuvir or NS5A-based Treatment Failure

[ ] Other (please explain) _____(*Required)

Q5: Will Epclusa be used as monotherapy and not in combination with another HCV direct acting antiviral agent? (Check only one that apply)

[ ] Yes

[ ] No (please explain and specify drug name that will be used with Epclusa) _____(*Required)

Q6: Has the member had an inadequate response, intolerance or experienced contraindication(s) (e.g., safety concerns, not indicated for patient's age/weight) to sofosbuvir/velpatasvir (generic Epclusa)? (Check only one that apply)

[ ] Yes (please explain) _____(*Required)

[ ] No

Q7: Has the member had an inadequate response, intolerance or experienced contraindication(s) (e.g., safety concerns, not indicated for patient's age/weight) to Mavyret (glecaprevir/pibrentasvir)? (Check only one that apply)

[ ] Yes (please explain) _____(*Required)

[ ] No

Q8: Is the request for continuation of prior brand Epclusa (sofosbuvir/velpatasvir) therapy? (Check only one that apply)

[ ] Yes

[ ] No (please explain if member cannot try generic Epclusa) _____ (*Required)

Q9: Is Epclusa prescribed by or in consultation with hepatologist, gastroenterologist, infectious disease specialist or HIV specialist certified through the American Academy of HIV Medicine? (Check only one that apply)

[ ] Yes (please provide the prescriber specialty) _____(*Required)

[ ] No (please provide the prescriber specialty) _____(*Required)

Q10: Will Epclusa be used in combination with ribavirin and not in combination with another HCV direct acting antiviral agent? (Check only one that apply)

[ ] Yes

[ ] No (please explain) _____(*Required)

Q11: Has the member had an inadequate response, intolerance or experienced contraindication(s) (e.g., safety concerns, not indicated for patient's age/weight) to sofosbuvir/velpatasvir (generic Epclusa)? (Check only one that apply)

[ ] Yes (please explain) _____(*Required)

[ ] No

Q12: Is the request for continuation of prior brand Epclusa (sofosbuvir/velpatasvir) therapy? (Check only one that apply)

[ ] Yes

[ ] No (please explain if member cannot try generic Epclusa) _____ (*Required)

Q13: Is Epclusa prescribed by or in consultation with hepatologist, gastroenterologist, infectious disease specialist or HIV specialist certified through the American Academy of HIV Medicine? (Check only one that apply)

[ ] Yes (please provide the prescriber specialty) _____(*Required)

[ ] No (please provide the prescriber specialty) _____(*Required)

Q14: Will Epclusa not be used in combination with another HCV direct acting antiviral agent? (Check only one that apply)

[ ] Yes

[ ] No (please explain and specify drug name that will be used with Epclusa)
_____(*Required)

Q15: Is the member ribavirin intolerant or ineligible? (Check only one that apply)

[ ] Yes (please explain) _____(*Required)

[ ] No

Q16: Will Epclusa be used in combination with ribavirin? (Check only one that apply)

[ ] Yes

[ ] No (please explain) _____(*Required)

Q17: Has the member had prior failure (defined as viral relapse, breakthrough while on therapy, or non-responder therapy) to Sovaldi or NS5A-based treatment? (Check only one that apply)

[ ] Yes (please explain) _____(*Required)

[ ] No

Q18: Has the member had an inadequate response, intolerance or experienced contraindication(s) (e.g., safety concerns, not indicated for patient's age/weight) to sofosbuvir/velpatasvir (generic Epclusa)? (Check only one that apply)

[ ] Yes (please explain) _____(*Required)

[ ] No

Q19: Is the request for continuation of prior brand Epclusa (sofosbuvir/velpatasvir) therapy? (Check only one that apply)

[ ] Yes

[ ] No (please explain if member cannot try generic Epclusa) _____ (*Required)

Q20: Is Epclusa prescribed by or in consultation with hepatologist, gastroenterologist, infectious disease specialist or HIV specialist certified through the American Academy of HIV Medicine? (Check only one that apply)

[ ] Yes (please provide the prescriber specialty) _____(*Required)

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[ ] No (please provide the prescriber specialty) _____(*Required)

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 designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	
Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	