BlueCross BlueShield Federal Employee Program.

HARVONI
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Harvoni (ledipasvir & sofosbuvir)

NOTE: Form must be completed in its **entirety** for processing

Please select strength: ❑ **33.75/150mg** ❑ **45/200mg** ❑ **90/400mg**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Is this a request for **INITIATION** or **CONTINUATION** of Harvoni? ***Please select answer below:***
   ❑ **CONTINUATION** of therapy **(PA Renewal)**, please answer the questions on **PAGE 3**
   ❑ **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑ Brand ❑ Generic
3. Does the patient have a diagnosis of hepatitis C? ❑Yes ❑No
4. Does the patient have a documented viral load (HCV RNA) from at least 6 months prior to this request for treatment? ❑Yes ❑No
5. Does the patient either have a poor prognosis and treatment cannot be delayed or have a past history where Hepatitis C infection is evident or suspected? ❑Yes*** (*If YES, please select one of the following below)** ❑No
   ❑Poor prognosis and treatment cannot be delayed ❑Past history where Hepatitis C infection is evident or suspected
6. Does the patient currently have a viral load (HCV RNA) present in the serum? ❑Yes ❑No
7. Does the patient have a history of hepatitis B (HBV) infection? ❑Yes***** ❑No
   ****If YES***, does the prescriber agree to monitor for HBV reactivation? ❑Yes ❑No
8. Has the patient had a kidney or liver transplant? ❑Kidney transplant ❑Liver transplant ❑No
9. What is the patient's genotype? ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑Not tested / Unspecified / Unknown
10. **If Genotype 1**: What was the pre-treatment HCV RNA? _____ million IU/mL ***(answer the following question below)***
    a. Will the HCV RNA be drawn at week 4? ❑Yes ❑No
11. Does the patient have a diagnosis of cirrhosis? ❑Yes***** ❑No
    ****If YES***, does the patient have a diagnosis of decompensated cirrhosis? ❑Yes ❑No
12. Is the patient treatment naïve? ❑Yes ❑No*****
    ****If NO***, was the patient previously treated with peginterferon and ribavirin with or without an NS3/4A protease inhibitor? ***Answer below:***
    ❑Peginterferon / Ribavirin ❑Peginterferon / Ribavirin **AND** an ****NS3/4A protease inhibitor
    ❑Other treatment ***(please specify)***: _____

    ****NS3/4A Protease Inhibitors: boceprevir (Victrelis), glecaprevir, grazoprevir, paritaprevir, simeprevir (Olysio), telaprevir (Incivek), voxilaprevir***

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Harvoni – FEP MD Fax Form Revised 5/31/2024

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

13. **Age 3-17**: What is the patient's weight? _____ kg **OR** _____ lbs

14. Will the patient be using this medication in combination with ribavirin? ***Please select answer below:***

❑ **Yes**: Please answer the following questions:

a. Does the patient have any significant or unstable cardiac disease? ❑Yes ❑No

b. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes***** ❑No

****If YES***, will pregnancy be excluded before the start of treatment? ❑Yes***** ❑No

****If YES***, will the patient be advised to use effective contraception during treatment with ribavirin and for 6 months after the final dose? ❑Yes ❑No

c. **MALE Patient**: Does the patient have a female partner of reproductive potential? ❑Yes***** ❑No

****If YES***, will pregnancy be excluded before the start of treatment? ❑Yes***** ❑No

****If YES***, will the patient be advised to use effective contraception during treatment with ribavirin and for 6 months after the final dose? ❑Yes ❑No

❑ **No**: Is the patient ribavirin eligible? ❑Yes ❑No

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Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)

Harvoni

(ledipasvir & sofosbuvir)

NOTE: Form must be completed in its **entirety** for processing

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1. Is this a request for **INITIATION** or **CONTINUATION** of Harvoni? ***Please select answer below:***
   ❑ **INITIATION** of therapy, please answer the questions on **PAGES 1 and 2**
   ❑ **CONTINUATION** of therapy **(PA Renewal)**, please answer the questions below:

2. Is this request for brand or generic? ❑ Brand ❑ Generic

3. Does the patient have a diagnosis of hepatitis C? ❑Yes ❑No

4. Was the patient's **PREVIOUS** approval for a Harvoni 8 week approval for a genotype 1 treatment naïve patient without cirrhosis and with a **PRE**-treatment HCV-RNA of less than 6 million IU/mL? ***Please select answer below:***
   ❑**Yes**: Was the patient evaluated at week 4 to determine that the viral load would not be met within 8 weeks of treatment? ❑Yes ❑No
   ❑**No** ***(select one of the following)***: ❑Previous approval was for 12 to 24 weeks ❑Previous approval was for a different medication

5. Will the patient be using this medication in combination with ribavirin? ❑Yes ❑No

6. **Age 3-17**: What is the patient's weight? _____ kg **OR** _____ lbs

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***

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