

North Carolina Department of Health and Human Services  
**Division of Medical Assistance**  
**Viekira Pak Continuation Prior Authorization Form**

**Recipient Information**

1. Recipient Name: \_\_\_\_\_ 2. Recipient ID #: \_\_\_\_\_

**Drug Information**

3. **Viekira Pak** 4. **112** Per 28 Days

5. Length of Therapy (Check ONE):

<input type="checkbox"/> <b>Last 4 weeks of 12</b> = Genotype 1a, without cirrhosis	VIEKIRA PAK + ribavirin
<input type="checkbox"/> <b>Last 4 weeks of 12</b> = Genotype 1a, with cirrhosis and treatment naïve	VIEKIRA PAK + ribavirin
<input type="checkbox"/> <b>Last 16 weeks of 24</b> = Genotype 1a, with cirrhosis and treatment experienced	VIEKIRA PAK + ribavirin
<input type="checkbox"/> <b>Last 4 weeks of 12</b> = Genotype 1b, without cirrhosis	VIEKIRA PAK
<input type="checkbox"/> <b>Last 4 weeks of 12</b> = Genotype 1b, with cirrhosis	VIEKIRA PAK + ribavirin
<input type="checkbox"/> <b>Last 16 weeks of 24</b> = Genotype 1x, liver transplant, F2 Stage or lower	VIEKIRA PAK + ribavirin

**Clinical Information**

1. HCV-RNA (IU/ml) \_\_\_\_\_ and/or log10 value \_\_\_\_\_ at week 3 or 4 of treatment cycle (must show less than 25IU/ml or 2log10 reduction in HCV-RNA to continue.)\*

2. HCV-RNA (IU/ml) \_\_\_\_\_ and/or log10 value \_\_\_\_\_ **documented on original Prior Authorization\***

**\*HCV-RNA lab test results MUST be attached to the PA to be approved.**

This form can be uploaded into the secure NCTracks Provider Portal, faxed, or mailed to CSC. If faxed, the Standard Drug Request Form **MUST** be the first page faxed. Fax all forms and lab work to CSC at: (855) 710-1969.  
Pharmacy PA Call Center: (866) 246-8505