

North Carolina Department of Health and Human Services
Division of Medical Assistance
Olysio Continuation Prior Authorization Form

Recipient Information

1. Recipient Name: _____ 2. Recipient ID #: _____

Drug Information

3. **Olysio** 4. **28** Per 28 Days

5. Length of Therapy (Check ONE):

___ **Last 4 weeks of 12** = Genotype 1 - Treatment-naïve patients and prior relapsers:

OLYSIO + Peg-IFN-alfa + RBV followed by an additional 12 weeks of Peg-IFN-alfa and RBV (total treatment duration of 24 weeks)

___ **Last 4 weeks of 12** = Genotype 1 - Prior non-responders (including partial and null responders):

OLYSIO + Peg-IFN-alfa + RBV followed by an additional 36 weeks of Peg-IFN-alfa and RBV (total treatment duration of 48 weeks)

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