

North Carolina Department of Health and Human Services
Division of Medical Assistance
Olysio 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)¹:

___ **First 8 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)

___ **First 8 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)

¹Approval will be for 8 weeks or as indicated above. A new PA is required with new HCV-RNA lab values to continue therapy

Clinical Information

1. The patient readiness to treat form is filled out and signed by the patient: YES or NO (circle one)*

2. The Child-Pugh Grade is: _____ (see Hepatitis-C Clinical Criteria)

3. The Genotype is: _____*

4. HCV-RNA (IU/ML) _____ and/or log10 value _____ (must be within last 6 months)*

5. Fibrosis stage _____ (see Hepatitis-C Clinical Criteria)*

6. Patient has tried and failed Viekira Pak: YES or NO (Circle One)

6a. IF NO, give clinical reason as to why Olysio must be used first: _____

* Readiness to treat form and **actual lab test** results (**NOT PROGRESS NOTES**) **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