North Carolina Department of Health and Human Services

Division of Medical Assistance

Harvoni Continuation PA Form

Recipient Information

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

Drug Information

3. **HARVONI** 4. **28** Per 28 Days

5. Length of Therapy (Check ONE):

___ **Last 4 weeks of 12** = Genotype 1 Treatment-naïve with or without cirrhosis

___ **Last 4 weeks of 12** = Genotype 1 Treatment-experienced without cirrhosis who have failed treatment with either + Peg-IFN-alfa + RBV or an HCV protease inhibitor + Peg-IFN-alfa + RBV

___ **Last 16 Weeks of 24** = Genotype 1 Treatment-experienced with cirrhosis who have failed treatment with either + Peg-IFN-alfa + RBV or an HCV protease inhibitor + Peg-IFN-alfa + RBV

___ **Last 4 Weeks of 12** = Genotype 4 with or without cirrhosis

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