



NC Medicaid  
Pharmacy Prior Approval Request for

Harvoni Tablet/Pellet Pack/Ledipasvir-Sofosbuvir: PA Request Form

Beneficiary Information

1. Beneficiary Last Name: \_\_\_\_\_ 2. First Name: \_\_\_\_\_  
3. Beneficiary ID #: \_\_\_\_\_ 4. Beneficiary Date of Birth: \_\_\_\_\_ 5. Beneficiary Gender: \_\_\_\_\_

Prescriber Information

6. Prescribing Provider NPI #: \_\_\_\_\_  
7. Requester Contact Information - Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_

Drug Information

8. Drug Name: \_\_\_\_\_ 9. Strength: \_\_\_\_\_ 10. Quantity Per 30 Days: 28  
11. Length of Therapy (in days):  365 Days

Clinical Information

Total length of therapy being requested (Check ONE):  
 8 weeks = Genotype 1 - Treatment-naïve without cirrhosis who have pre-treatment HCV RNA less than 6 million IU/mL  
 12 weeks = Genotype 1, 4, 5, or 6 - Treatment-naïve and treatment-experienced without cirrhosis or with compensated cirrhosis (Child-Pugh A)  
 24 weeks = Treatment-experienced with compensated cirrhosis (Child-Pugh A)  
 Harvoni + ribavirin 12 weeks = Genotype 1 - Treatment-naïve and treatment-experienced with decompensated cirrhosis (Child-Pugh B or C) or Genotype 1 or 4 – Treatment-naïve and treatment-experienced liver transplant recipients without cirrhosis, or with compensated cirrhosis (Child-Pugh A) 1.  
1. What is the beneficiary's Genotype? \_\_\_\_\_  
2. Is the beneficiary 3 years of age or older with a diagnosis of Chronic Hepatitis C (CHC) infection with genotype 1, 4, 5 or 6 infection without cirrhosis or with compensated cirrhosis?  Yes  No  
3. Is the beneficiary 3 years of age or older with genotype 1 infection with decompensated cirrhosis, in combination with ribavirin?  Yes  No  
4. Is the beneficiary 3 years of age or older with genotype 1 or 4 infection who is a liver transplant recipient without cirrhosis or with compensated cirrhosis, in combination with ribavirin?  Yes  No  
5. As the provider, are you reasonably certain that treatment will improve the beneficiary's overall health status?  Yes  No  
6. Does the beneficiary have FDA labeled contraindications to Harvoni or generic ledipasvir/sofosbuvir?  
 Yes  No  
7. Is Harvoni® or generic ledipasvir/sofosbuvir is being used in combination with other drugs containing sofosbuvir?  Yes  No

Signature of Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSRA at (855) 710-1969  
DHB Pharmacy \_\_

Pharmacy PA Call Center: (866) 246-8505