HEPATITIS C PRIOR AUTHORIZATION REQUEST FORM

Prescribing Physician	
Name (First, Last)	
Physician Specialty	
Phone #	Fax #
Name and title of person completing form (please print)	

Patient	
Name (First, Last)	
Sex (at birth) □ Male □ Female	Phone #
Client	ID#
Date of Birth	Age

1. Please select ONE of the following:

□ Elbasvir-Grazoprevir (Zepatier®)
□ Glecaprevir-Pibrentasvir (Mavyret®)
□ Ledipasvir-Sofosbuvir (Harvoni®)
□ Sofosbuvir (Sovaldi®)
□ Sofosbuvir-Velpatasvir (Epclusa®)
□ Sofosbuvir-Velpatasvir-Voxilaprevir (Vosevi®)

Dose: **Frequency:** **Length of Therapy:**

2. Does this patient have a diagnosis of Chronic Hepatitis C? □ Yes □ No

3. What is the Hepatitis C Genotype?

4. Has this patient been treated for Hepatitis C previously? □ Yes □ No

If yes, provide drug name, duration of therapy, last treatment date:

Provide the reason for retreatment:

5. Does this patient have a history of cirrhosis? □ Yes □ No

6. Submit Hepatitis C genotype and Hepatitis C RNA viral load (within 12 months) □ Yes □ No

Please indicate pertinent laboratory tests or procedures for this diagnosis:

Procedure/Lab:	Findings:	Date:

Physician's Name (print) _____ **Title** _____

Physician's Signature _____ **Date** _____

Fax PA request form AND supporting documentation to: SGRX @ 313-264-0985