US Family Health Plan
Prior Authorization Request Form for

daclatasvir (**Daklinza**), sofosbuvir/velpatasvir (**Epclusa**), ledipasvir/sofosbuvir (**Harvoni**), glecaprevir/ pibrentasvir (**Mavyret**), simeprevir (**Olysio**), sofosbuvir (**Sovaldi**), itaprevir/ritonavir/ombitasvir (**Technivie**), grazoprevir/elbasvir (**Zepatier**), paritaprevir /ritonavir/ombitasvir/dasabuvir (**Viekira XR** and **Viekira Pak**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorizations will expire in 1 year.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Please indicate which medication is being prescribed: _____

Step 2 **Please complete the clinical assessment:**

1. The branded agents on the top of this form are the preferred agents for Tricare. If the authorized generics of either Epclusa or Harvoni are required, please stop filling out this form and complete the separate PA form specific for the authorized generic product.	☐ Acknowledged. Proceed to question 2	
2. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question 3	☐ No **STOP** **Coverage not approved**
3. Is the requested medication prescribed by or in consultation with a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician?	☐ Yes Proceed to question 4	☐ No **STOP** **Coverage not approved**
4. Does the patient have laboratory evidence of chronic hepatitis C virus (HCV) infection?	☐ Yes Proceed to question 5	☐ No **STOP** **Coverage not approved**

5. What is the HCV genotype?	☐ **Genotype 1a - Sign and date below** ☐ **Genotype 1b or other genotype 1 subtype - Sign and date below** ☐ **Genotype 2b - Sign and date below** ☐ **Genotype 3 - Sign and date below** ☐ **Genotype 4 - Sign and date below** ☐ **Genotype 5 - Sign and date below** ☐ **Genotype 6 - Sign and date below** ☐ **All others – STOP - Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____