US Family Health Plan
Prior Authorization Request Form for
Sofosbuvir/velpatasvir (Epclusa), Ledipasvir/sofosbuvir (Harvoni), Sofosbuvir (Sovaldi) Grazoprevir/elbasvir (Zepatier), Paritaprevir/ritonavir/ombitasvir/dasabuvir (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 855-273-5735

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**

Clinical documentation may be required for approval.
Prior authorizations will expire in 12 months.

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:**

Question		
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. What is the requested medication?	☐ Epclusa, Harvoni, or Sovaldi- Proceed to question **3** ☐ Viekira Pak- Proceed to question **4** ☐ Zepatier- Proceed to question **5**	
3. Is the patient greater than or equal to 3 years of age?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
4. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
5. Is the patient greater than or equal to 12 years of age?	☐ Yes Proceed to question **7**	☐ No Proceed to question **6**

6. Does the patient weigh 30 kilograms or more?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. 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 **8**	☐ No **STOP** **Coverage not approved**
8. Does the patient have laboratory evidence of chronic hepatitis C virus (HCV) infection?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. What is the HCV genotype?	☐ **Genotype 1a - Sign and date below** ☐ **Genotype 1b or other genotype 1 subtype - Sign and date below** ☐ **Genotype 2 - 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 __________

[13 November 2024]