



**NC Medicaid and NC Health Choice  
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):  8 Weeks  12 Weeks  24 Weeks

**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. Is the beneficiary 3 years or older w/ a diagnosis of Chronic Hepatitis C (CHC) infection w/ confirmed genotype 1, 4, 5 or 6 infection without cirrhosis or w/ compensated cirrhosis, or genotype 1 infection w/ decompensated cirrhosis, in combination w/ ribavirin; or genotype 1 or 4 infection who are liver transplant recipients without cirrhosis or w/ compensated cirrhosis, in combination w/ ribavirin?  Yes  No **Genotype:** \_\_\_\_\_

2. Are medical records documenting the diagnosis of chronic hepatitis C with genotype and subtype attached?  Yes  No **\*\*Lab test results MUST be attached to the PA to be approved.\*\***

3. Does the beneficiary have a documented quantitative HCV RNA at baseline that was tested within the past 6 months (medical documentation required)?  Yes  No **HCV RNA (IU/ml):** \_\_\_\_\_ and/or **log10 value** \_\_\_\_\_

4. Will Harvoni be 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.