Prior Authorization Form

Hepatitis C Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested (*check one*):

☐ **Incivek®** ☐ **Victrelis®**

Date: ______________________ Patient ID#: ______________ DOB:__________

Patient Name: __________________________ Provider NPI: __________________________

Prescribing Physician: ______________________ Office Contact: __________________________

Office Fax #: __________________________ Office Phone: __________________________

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. DIAGNOSIS FOR DRUG REQUESTED:

☐ Hepatitis C genotype 1 ☐ Other (specify)__________________________

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

☐ **N/A** If none or not applicable to diagnosis, indicate "N/A."

Drug Name	Date	Duration
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

3. PATIENT HISTORY:

a. Does the patient have compensated liver disease? ☐ Yes ☐ No ☐ N/A

Please add any other supporting medical information that may be useful in the decision making process including contraindications to medications related to the diagnosis:

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FAX: (888) 671-5285 or EMAIL: FSS_Standard_Medicare@catalystrx.com

YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL