HARVONI
PRIOR AUTHORIZATION
SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Harvoni must meet the following criteria:

- Patient must be ≥ 18 years old.
- Must have a diagnosis of chronic hepatitis C (genotype 1).
- Liver biopsy confirming a Metavir score of F3 or F4, unless medically contraindicated; or documentation of severe extrahepatic manifestations of hepatitis C infection.
- Must be prescribed by a hepatologist, gastroenterologist, or infectious disease specialist.
- Absence of renal impairment (eGFR must be >30mL/min/1.73m^2) and absence of end stage renal disease (ESRD).
- Documentation showing that patient is drug and alcohol free for the past 6 months.
- The concomitant use of Harvoni and P-gp inducers (rifampin, St. John's wort), certain anticonvulsants, certain antiretrovirals, and rosuvastatin is not recommended.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH:

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	NAME OF SPECIALIST:
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug:	Diagnosis for this request:	Documented liver fibrosis:	Patient is drug and alcohol free for past 6 months:
□ **Harvoni** Dosage: _____	Genotype:	□ YES □ NO	□ YES □ NO eGFR:

Has the patient been previously treated for chronic hepatitis C? □ YES □ NO If yes, please indicate past treatment regimen(s), dates of treatment, and response to therapy:	Baseline HCV RNA: HCV RNA 4 weeks after starting therapy:
PHYSICIAN SIGNATURE:	DATE:

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX: ( )
DRUG:	NDC#

Part V: FOR OFFICIAL USE ONLY

Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	