

North Carolina Department of Health and Human Services  
**Division of Medical Assistance**  
**Daklinza Prior Authorization Form**

**Recipient Information**

1. Recipient Name: \_\_\_\_\_ 2. Recipient ID #: \_\_\_\_\_

**NOTE: SOVALDI® PRIOR AUTHORIZATION FORM MUST ALSO BE FILLED OUT**

**Drug Information**

3. **Daklinza** 4. **28** Per **28** Days

5. Length of Therapy (Check ONE)<sup>1</sup>:

\_\_\_ **8 weeks of 12=** Genotype 3

Sovaldi® + Daklinza®<sup>2</sup>

<sup>1</sup>Approval will be for 8 weeks unless otherwise noted above. A new PA is required with new HCV-RNA lab values to continue therapy

<sup>2</sup>For Genotype 3, the Sovaldi Prior Authorization Form must also be filled out and sent in

**Clinical Information**

1. The patient readiness to treat form is filled out and signed by the patient: **YES or NO (circle one)\***

2. The Child-Pugh Grade is: \_\_\_\_\_ (see Hepatitis-C Clinical Criteria)

3. The Genotype is: \_\_\_\_\_\*

4. HCV-RNA (IU/ML) \_\_\_\_\_ and/or log10 value \_\_\_\_\_ (must be within last 6 months)\*

5. Fibrosis stage \_\_\_\_\_ (see Hepatitis-C Clinical Criteria)\*

6. Is there a reason the beneficiary cannot use Eplusera? **YES or NO (circle one) Explain:**

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\* Readiness to treat form and **actual lab test** results (**NOT PROGRESS NOTES**) **MUST** be attached to the PA to be approved.

This form can be uploaded into the secure NCTracks Provider Portal, faxed, or mailed to CSC. If faxed, the Standard Drug Request Form **MUST** be the first page faxed. Fax all forms and lab work to CSC at: (855) 710-1969.

Pharmacy PA Call Center: (866) 246-8505