carolina complete health

Vosevi Continuation PA Form

Recipient Information

1. Recipient Last Name:___________________________ 2. First Name:____________________________

3. Recipient ID #:_____________4. Recipient Date of Birth:____________ 5. Recipient Gender:_________

Prescriber Information

6. Prescribing Provider NPI#:________________

7. Requester Contact Information - Name:__________________ Phone #: ____________Ext:__________

Drug Information

8. **Vosevi** 9. ______ Per 28 Days

10. Length of Therapy (Check ONE):

___ **4 more weeks**

Clinical Information

1. HCV-RNA (IU/ml) ______ and/or log10 value ______ (Baseline values before Vosevi)
2. HCV-RNA (IU/ml) ______ and/or log10 value ______ at week 4 or later of Vosevi treatment cycle

(must show less than 25IU/ml or 2log10 reduction in HCV-RNA to continue.)*

* **HCV-RNA lab test results MUST be attached to the PA to be approved.**

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.

Fax this form to: (877) 386-4695 Pharmacy PA Call Center: (833) 585-4309