carolina complete health

Vosevi Prior Authorization 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. Drug Name:__**Vosevi**__ 9. _____Per 28 Days

10. Total Length of Therapy (Check ONE):

___ **12 weeks = All genotypes previously treated with an HCV regimen containing an NS5A inhibitor**
(only 8 weeks can be approved with this form. Must use continuation form to request last 4 weeks).
List previous med tried_____

___ **12 weeks = Genotypes 1a or 3 previously treated with an HCV regimen containing Sofosbuvir without an NS5A**
(only 8 weeks can be approved with this form. Must use continuation form to request last 4 weeks).
List previous med tried_____

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) *

***Readiness to treat form and actual lab test results (NOT PROGRESS NOTES) 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