carolina complete health

## Pharmacy Prior Approval Request for Sofosbuvir-Velpatasvir – Continuation PA Request Form

**Beneficiary Information**

1. Beneficiary Last Name: _________________________ 2. First Name: _______________________________________
3. Beneficiary ID #: ________________ 4. Beneficiary Date of Birth: _______________ 5. Beneficiary Gender: ____

**Prescriber Information**

6. Prescribing Provider NPI #: _________________________________________________
7. Requester Contact Information - Name: _____________________________ Phone #: _________________ Ext. ____

**Drug Information**

8. Drug Name: ____________________________ 9. Strength: _______________ 10. Quantity Per 30 Days: __28__
11. Length of Therapy (in days): ☒ 4 Weeks (Do not change. Only 4 weeks can be approved with this form.)

**Clinical Information**

1. Have HCV RNA labs been collected four (4) or more weeks after the initial prescription fill date? (Medical documentation with results are required)? ☐ **Yes** ☐ **No**
2. Do the results of the HCV RNA labs indicate a response to therapy (>/= 2 log reduction in HCV RNA or HCV RNA < 25IU/ml)? ☐ **Yes** ☐ **No**

   **At week 4 of the treatment cycle:**

   HCV RNA (IU/ml): _______
   And/or log 10 value: _______

   **Before treatment documented on original Prior Authorization request:**

   HCV RNA (IU/ml): _______
   And/or log 10 value: ________

3. Has the beneficiary exhibited any sign of high risk behavior (ex. recurring alcoholism, IV drug use, etc.)? ☐ **Yes** ☐ **No**
4. Has the beneficiary failed to complete HCV disease evaluation appointments or procedures? ☐ **Yes** ☐ **No**
5. During the initial course of therapy, was the beneficiary compliant with the prescribed medication regimen? ☐ **Yes** ☐ **No**
6. Has the beneficiary's medication fill history been reviewed for compliance? ☐ **Yes** ☐ **No**

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: (866)-399-0929 Pharmacy PA Call Center: (833) 585-4309