carolina complete health

Pharmacy Prior Approval Request for Vosevi: Continuation PA Form

Member Information

1. Member Last Name: _____ 2. First Name: _____
3. Member ID #: _____ 4. Member Date of Birth: _____ 5. Member 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 Member exhibited any sign of high risk behavior (ex. recurring alcoholism, IV drug use, etc.)?
   ☐ **Yes** ☐ **No**
4. Has the Member failed to complete HCV disease evaluation appointments or procedures?
   ☐ **Yes** ☐ **No**
5. During the initial course of therapy, was the Member compliant with the prescribed medication regimen?
   ☐ **Yes** ☐ **No**
6. Has the Member'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.