Pharmacy Prior Approval Request for Vosevi: Initial PA 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): ☒ 8 Weeks (Only 8 weeks can be approved with this form. You must use continuation form to request last 4 weeks)

Clinical Information

1. Is the beneficiary 18 years of age or older with a diagnosis of chronic Hepatitis C (CHC) infection with confirmed genotype 1,2,3,4,5, or genotype 6 without cirrhosis or with compensated cirrhosis?
   ☐ **Yes** ☐ **No Genotype is: _____ Child-Pugh Grade: _______**
2. Has the beneficiary previously been treated with an HCV regimen containing an NS5A inhibitor and have a genotype of 1, 2, 3, 4, 5, or 6; or has the beneficiary previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor and has a genotype of 1a or genotype 3?
   ☐ **Yes** ☐ **No**
3. Are medical records documenting the diagnosis of chronic hepatitis C with genotype and subtype being submitted with this request? ☐ **Yes** ☐ **No** ****Lab test results MUST be attached to the PA to be approved.****
4. Which of the following are included with the submitted medical records to document the staging of liver disease:
   ☐ Metavir scores ☐ FibroSURE score ☐ IASL scores
   ☐ Batts-Ludwig scores ☐ Fibroscan score ☐ Ishak scores
   ☐ APRI score Radiological imaging consistent with cirrhosis
   ☐ Physical findings or clinical evidence consistent with cirrhosis as attested by the prescribing physician
5. Does the beneficiary have a documented quantitative HCV RNA at baseline that was tested within the past 6 months (medical documentation required)? ☐ **Yes** ☐ **No HCV RNA (IU/ml): _______ and/or log10 value: _______**
6. As the provider, are you reasonably certain that treatment will improve the beneficiary's overall health status?
   ☐ **Yes** ☐ **No**
7. Does the beneficiary have an FDA labeled contraindications to Vosevi? ☐**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