carolina complete health

Pharmacy Prior Approval Request for Sofosbuvir-Velpatasvir (generic for Epclusa)

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): ☐ 12 Weeks

Clinical Information

1. Is the beneficiary 3 years of age or older with a diagnosis of chronic hepatitis C (CHC) with confirmed genotype 1, 2, 3, 4, 5, or 6? ☐ **Yes** ☐ **No Genotype is: _____**
2. 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.****
(documentation of genotype waived if treatment naïve beneficiaries)
3. 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: _____**
4. As the provider, are you reasonably certain that treatment will improve the beneficiary's overall health status?
☐ **Yes** ☐ **No**
5. Does the beneficiary have FDA-labeled contraindications to sofosbuvir-velpatasvir? ☐ **Yes** ☐ **No**
6. Will sofosbuvir-velpatasvir be used in combination with other drugs containing sofosbuvir? ☐ **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: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/