

Ticket #: _____ Request Date: _____ Request Time: _____

Sovaldi® Prior Authorization Request Form (Page 1 of 2)
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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Chronic hepatitis C (CHC)	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	

<p>Clinical Information: Document the patient's HCV genotype*: _____ Will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has a diagnosis of chronic hepatitis C genotype 1, 2, 3, or 4?* <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please note: Chart documentation of the above is required to be submitted along with this fax.</i> Select if Sovaldi is prescribed by or in consultation with one of the following specialists: <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> HIV specialist certified through the American Academy of HIV Medicine <input type="checkbox"/> Hepatologist <input type="checkbox"/> Infectious disease specialist Is this request for continuation of prior Sovaldi (sofosbuvir) therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Select if the patient has had a trial and failure, contraindication, or intolerance to the following, as appropriate for the patient's genotype: <input type="checkbox"/> Harvoni <input type="checkbox"/> Epclusa <input type="checkbox"/> Zepatier Select if the patient will be using Sovaldi in combination with the following medication(s): <input type="checkbox"/> Peginterferon alfa and ribavirin <input type="checkbox"/> Ribavirin <input type="checkbox"/> Olysio <input type="checkbox"/> Daklinza Does the patient have decompensated liver disease (e.g., Child –Pugh Class B or C)? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient experienced failure with a previous treatment regimen that includes Sovaldi? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>For Sovaldi + ribavirin in patients with genotype 1, 2, 3, or 4, also answer the following: Document the patient's weight: _____ lbs/kg Is the patient a liver transplant recipient? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>For Sovaldi + Olysio in patients with genotype 1, also answer the following: Does the patient have cirrhosis? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have NS5A inhibitor resistant-associated variants as confirmed by commercially available assays? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient experienced failure with a previous treatment regimen that includes Olysio or other HCV NS3/4A protease inhibitors [e.g., Incivek (telaprevir), Victrelis (boceprevir)]? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Please note that this form is to be completed by the prescribing physician. This document and others, if attached, contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**
 Office use only: Sovaldi_Comm5/2019

Sovaldi® Prior Authorization Request Form (Page 2 of 2)
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For Sovaldi + Daklinza in patients with genotype 1 or 3, also answer the following:

- Does the patient have decompensated cirrhosis? Yes No
Is the patient a liver transplant recipient? Yes No
Has the patient failed prior HCV NS5A-containing regimen (e.g., Daklinza)? Yes No
Is this request for continuation of prior Sovaldi plus Daklinza therapy? Yes No

Quantity Limit Requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- Titration or loading dose purposes
 Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
 Requested strength/dose is not commercially available
 Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Authorized Medical Signature:

Telephone:

Date:

When Completed Return To:

MC-Rx Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

Please note: This request may be denied unless all required information is received.