

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

Sovaldi® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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:

Chronic hepatitis C (CHC)

Other diagnosis: _____ ICD-10 Code(s): _____

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? Yes No

**Please note: Chart documentation of the above is required to be submitted along with this fax.*

Select if Sovaldi is prescribed by or in consultation with one of the following specialists:

Gastroenterologist HIV specialist certified through the American Academy of HIV Medicine

Hepatologist Infectious disease specialist

Is this request for continuation of prior Sovaldi (sofosbuvir) therapy? Yes No

Select if the patient has had a trial and failure, contraindication, or intolerance to the following, as appropriate for the patient's genotype:

Harvoni Epclusa Zepatier

Select if the patient will be using Sovaldi in combination with the following medication(s):

Peginterferon alfa and ribavirin Ribavirin Olysio Daklinza

Does the patient have decompensated liver disease (e.g., Child –Pugh Class B or C)? Yes No

Has the patient experienced failure with a previous treatment regimen that includes Sovaldi? Yes No

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? Yes No

For Sovaldi + Olysio in patients with genotype 1, also answer the following:

Does the patient have cirrhosis? Yes No

Does the patient have NS5A inhibitor resistant-associated variants as confirmed by commercially available assays? Yes 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)]? Yes No

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_Comm_2017Dec

Sovaldi® Prior Authorization Request Form (Page 2 of 2)
DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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:

ProCare PBM 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.

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_Comm_2017Dec