

Vosevi™ (Sofosbuvir/Velpatasvir/Voxilaprevir) Initiation Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____
 Pharmacy NPI: _____ Pharmacy Phone: _____ Pharmacy Fax: _____
 Pharmacy Name: _____ Pharmacist Name: _____
 Prescriber NPI: _____ Prescriber Name: _____ Specialty: _____
 Prescriber Phone: _____ Prescriber Fax: _____ Drug Name: _____
 NDC: _____ Start Date: _____

Clinical Information

- HCV Genotype (including subtype if applicable): _____ Date Determined: _____
- METAVIR Equivalent Fibrosis Stage: _____ Testing Type: _____
Date Fibrosis Stage Determined: _____
- Pre-Treatment Viral Load: _____ Date Determined: _____
- Does member have decompensated hepatic disease or moderate-to-severe hepatic impairment (Child-Pugh B or C)? Yes ___ No ___
- Is the member currently on hospice or does the member have a limited life expectancy (less than 12 months) that cannot be remediated by treating HCV? Yes ___ No ___
- Does the member have severe renal impairment (estimated eGFR <30mL/min/m²? Yes ___ No ___
- Has the member been evaluated by a gastroenterologist, infectious disease specialist, or a transplant specialist within the past 3 months? Yes ___ No ___
- If yes, please include name of specialist recommending hepatitis C treatment: _____
- Has the member been previously treated for hepatitis C? Yes ___ No ___
- Did the member's prior treatment regimen contain an NS5A inhibitor (e.g, daclatasvir, elbasvir, ledipasvir, ombitasvir, velpatasvir)? Yes ___ No ___
- Please indicate previous treatment regimen and reason for failure (relapser, null-responder, partial responder): _____
- Please indicate requested regimen below:
 Vosevi™ 400mg/100mg/100mg daily x 84 days (12 weeks)
 Other: _____
- Has the member signed the intent to treat contract**? Yes ___ No ___ ***Required for processing of request*
- Has the member been counseled on the harms of illicit IV drug use and alcohol use and agreed to not use illicit IV drugs or alcohol while on or after they finish hepatitis C treatment? Yes ___ No ___
- Has the member initiated immunization with the hepatitis A and B vaccines? Yes ___ No ___
- For women of childbearing potential (and male patients with female partners of childbearing potential):
 Patient is not pregnant (or a male with a pregnant female partner) and not planning to become pregnant during treatment
 Agreement that partners will use two forms of effective non-hormonal contraception during treatment. Please list non-hormonal birth control options discussed with member _____
- Is the member taking any of the following medications: H2-antagonists at doses greater than 40mg famotidine equivalent, omeprazole doses greater than 20mg daily or other proton pump inhibitors, amiodarone, carbamazepine, eslicarbazepine, phenytoin, phenobarbital, oxcarbazepine, rifampin, rifabutin, rifapentine, atazanavir, lopinavir, tipranavir/ritonavir, efavirenz, St. John's wort, pravastatin doses greater than 40mg, rosuvastatin, pitavastatin, cyclosporine, methotrexate, mitoxantrone, imatinib, irinotecan, lapatinib, sulfasalazine, or topotecan? Yes ___ No ___
- If member is using antacids have they agreed to separate antacid and Vosevi™ administration by 4 hours? Yes ___ No ___ NA ___
- Have all other clinically significant issues been addressed prior to starting therapy? Yes ___ No ___
 I recommend this patient be followed by an OHCA Care Management Nurse.

Members must be adherent for continued approval. Treatment gaps of therapy longer than 3 days will result in denial of payment for subsequent requests for continued therapy. Refills must be prior authorized.

Prescriber Signature: _____ **Date:** _____

Has the member been counseled on appropriate use of Vosevi™ therapy? Yes ___ No ___

Pharmacist Signature: _____ **Date:** _____

Please do not send in chart notes. Failure to complete this form in full will result in processing delays. By signature, the prescriber or pharmacist confirms the above information is accurate.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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