AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Sovaldi

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 28 Days: _____
11. Length of Therapy: ___12 weeks ___24 weeks ___48 weeks

Clinical Information

Total length of therapy being requested (Check ONE):

___ **12 weeks** = Genotype 1, 2, or 4 for treatment-naïve and treatment-experienced adult beneficiaries without cirrhosis or with compensated cirrhosis (child-pugh A); or genotype 2 for treatment-naïve and treatment-experienced pediatric patients, 3 years of age or older, without cirrhosis or with compensated cirrhosis (child-pugh A).

- Genotype 1 and previously treated with a regimen containing an NS3/4A PI2 without prior treatment with an NS5A inhibitor.

___ **24 weeks** = Genotype 1 adult beneficiaries that are PEG-interferon ineligible; genotype 3 for treatment-naïve and treatment experienced adults without cirrhosis or with compensated cirrhosis (child-pugh A); Or genotype 3 for treatment-naïve and treatment-experienced pediatric patients, 3 years of age or older, without cirrhosis or with compensated cirrhosis (child-pugh A).

___ **48 weeks** = Genotype 1,2,3, or 4 for adult beneficiaries with a diagnosis of Hepatocellular Carcinoma awaiting liver transplantation (up to 48 weeks or until liver transplantation, whichever comes first).

1. Does the beneficiary have a diagnosis of chronic hepatitis C infections with one of the following confirmed diagnoses:
___ Genotype 1 or 4 without cirrhosis or with compensated cirrhosis and beneficiary is 18 years of age or older
___ Genotype 2 or 3 without cirrhosis or with compensated cirrhosis and beneficiary is 3 years of age or older
___ Beneficiary has CHC infection with hepatocellular carcinoma awaiting liver transplant
2. As the provider, are you reasonably certain that treatment will improve the beneficiary's overall health status? Yes___ No___
3. Is Sovaldi being prescribed in combination with ribavirin and pegylated interferon alfa for genotypes 1 and 4? Yes___ No___
4. Is Sovaldi being prescribed in combination with ribavirin for beneficiaries with genotype 1 who are peginterferon-ineligible (medical record documentation of previous peginterferon therapy or reason for ineligibility must be submitted for review)? Yes___ No___
5. Is Sovaldi being prescribed in combination with ribavirin for genotypes 2 and 3 and/or in CHC beneficiaries with hepatocellular carcinoma awaiting liver transplant? Yes___ No___
6. Is Sovaldi being used as monotherapy? Yes___ No___
7. Is Sovaldi being used with any other sofosbuvir-containing regimen? Yes___ No___
8. Does the beneficiary have any FDA labeled contraindications to sofosbuvir (Sovaldi)? Yes___ No___
9. Is the Beneficiary pregnant? Yes___ No___
10. Has the beneficiary tried and failed 2 preferred medications in this class or does the beneficiary have a reason or contraindication to the preferred medications in the class? Yes___ No___

Please list tried/failed medications and/or any contraindications to the preferred medications: _____
_____

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: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406