OKLAHOMA Health Care Authority

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State of Oklahoma
SoonerCare
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

1. HCV Genotype (including subtype if applicable):_____ Date Determined:_____
2. METAVIR Equivalent Fibrosis Stage:_____ Testing Type:_____
   Date Fibrosis Stage Determined:_____
3. Pre-treatment viral load in the last 12 months:_____ Date Taken:_____
   For METAVIR score of <F1, 2nd test must confirm chronic HCV diagnosis at least 6 months after 1st test.
   Prior pre-treatment viral load or antibody test:_____ Date Taken:_____
4. Does member have decompensated hepatic disease or Child-Pugh B or C? Yes☐ No☐
5. 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☐
6. Has the member been evaluated by a gastroenterologist, infectious disease specialist, or a transplant specialist within the past 3 months? Yes☐ No☐
7. If yes, please include name of specialist recommending hepatitis C treatment: _____
8. Has the member been previously treated for hepatitis C? Yes☐ No☐
9. Did the member's prior treatment regimen contain an NS5A inhibitor (e.g., daclatasvir, elbasvir, ledipasvir, ombitasvir, velpatasvir)? Yes☐ No☐
10. Please indicate previous treatment regimen and reason for failure (relapser, null-responder, partial responder):
    _____
11. Please indicate requested regimen below:
    - ☐ Vosevi® 400mg/100mg/100mg daily x 84 days (12 weeks)
    - ☐ Other:_____
12. Has the member signed the intent to treat contract**? Yes☐ No☐ ***Required for processing of request ****
13. Has the member been counseled on the harms of illicit IV drug use and alcohol use? Yes☐ No☐
14. Has the member initiated immunization with the hepatitis A and B vaccines? Yes☐ No☐
15. 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_____
16. 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☐
17. If member is using antacids have they agreed to separate antacid and Vosevi® administration by 4 hours?
    Yes☐ No☐ NA☐
18. Have all other clinically significant issues been addressed prior to starting therapy? Yes☐ No☐

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.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.