

**Sovaldi® (Sofosbuvir) Initiation Prior Authorization Form**

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Member D#: \_\_\_\_\_  
 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): \_\_\_\_\_ 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 (CTP class 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. If yes, please indicate previous treatment regimen and reason for failure (relapser, null-responder, partial responder): \_\_\_\_\_
10. Please indicate dosage form, strength, and regimen below:
 

<input type="checkbox"/> Sovaldi® 400mg tablets	<input type="checkbox"/> once daily with weight-based ribavirin (RBV) and weekly peginterferon (PEG/IFN) x 84 days (12 weeks)
<input type="checkbox"/> Sovaldi® 200mg tablets	<input type="checkbox"/> once daily with RBV x 84 days (12 weeks)
<input type="checkbox"/> Sovaldi® 200mg oral pellets	<input type="checkbox"/> once daily with RBV x 112 days (16 weeks)
<input type="checkbox"/> Sovaldi® 150mg oral pellets	<input type="checkbox"/> once daily with RBV x 168 days (24weeks)
<input type="checkbox"/> Other: _____	
11. If member is interferon (IFN) ineligible, please specify reasoning: \_\_\_\_\_
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):
 

<input type="checkbox"/> Patient is not pregnant (or a male with a pregnant female partner) and not planning to become pregnant during treatment or within 6 months of completing treatment
<input type="checkbox"/> Agreement that partners will use two forms of effective non-hormonal contraception during treatment and for at least 6 months after completing treatment. Please list non-hormonal birth control options discussed with member _____
<input type="checkbox"/> Verification that monthly pregnancy tests will be performed throughout treatment for ribavirin users
16. Is the member taking any of the following medications: amiodarone, rifampin, rifabutin, rifapentine, carbamazepine, eslicarbazepine, phenytoin, oxcarbazepine, tipranavir/ritonavir, didanosine or St. John's wort? Yes \_\_\_ No \_\_\_
17. 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 Sovaldi™ therapy? Yes \_\_\_ No \_\_\_

**Pharmacist Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Please do not send in chart notes. Specific information/documentation will be requested if necessary. Failure to complete this form in full will result in processing delays. By signature, the prescriber or pharmacist confirms the above information is accurate.*

<p><u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u></p> <p>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</p>	<p><u>CONFIDENTIALITY NOTICE</u></p> <p><i>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</i></p>
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