SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Sovaldi™ 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): _____ 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 regimen below (if member is IFN ineligible please specify reasoning):
    - ❑ Sovaldi™ plus RBV plus weekly PEG/IFN 12 weeks
    - ❑ Sovaldi™ plus RBV 12 weeks
    - ❑ Sovaldi™ plus RBV 16 weeks
    - ❑ Sovaldi™ plus RBV 24 weeks
    - ❑ Sovaldi™ plus Daklinza™ 12 weeks ***Must also submit Daklinza™ Initiation Prior Authorization Form*
    - ❑ Other:_____
      (if also requesting Olysio®, the Olysio® Initiation Prior Authorization Form will also need to be submitted)
11. Has the member signed the intent to treat contract**? Yes___ No___ ***Required for processing of request.*
12. 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____
13. Has the member initiated immunization with the hepatitis A and B vaccines? Yes___ No___
14. 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 or within 6 months of completing treatment
    - ❑ 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_____
    - ❑ Verification that monthly pregnancy tests will be performed throughout treatment for ribavirin users
15. 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___
16. Have all other clinically significant issues been addressed prior to starting therapy? Yes___ No____

❑ This patient is in need of additional support. 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 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.

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