Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Sovaldi® (sofosbuvir)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

What is the provider's specialty?

☐ Gastroenterologist ☐ Hepatologist ☐ Infectious disease specialist ☐ Other: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Sovaldi 400mg tablet

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Requested Duration: ☐ 12 weeks ☐ 24 weeks ☐ Other _____

Precertification Requirements

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

1. Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist
2. Must be age 12 or older
3. Must have chronic hepatitis C infection
   - For genotypes 2 or 3, must first try Epclusa
   - For genotypes 1, 4, 5, or 6, must first try Harvoni
4. Must not be taken as monotherapy

Additional information

Note: Criteria (including criteria for duration of approval) will be applied consistent with current AASLD/IDSA (American Association for the Study of Liver Disease/Infectious Disease Society of America) guidelines

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 01/2018
Last reviewed 09/2018

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Chronic hepatitis C infection
☐ *Other – the patient's condition is:* _____

B. What is the patient's HCV genotype?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

C. Has the patient previously received treatment for chronic hepatitis C?

☐ Yes, the drug(s) used were: _____
☐ No

D. If genotype 1, 4, 5, or 6, has the patient first tried Harvoni?

☐ Yes, for _____ weeks from _____ (list dates)
☐ No, because _____

E. If genotype 2 or 3, has the patient first tried Epclusa?

☐ Yes, for _____weeks from _____(list dates)
☐ No, because _____

F. What drug combination will be used with Sovaldi? Check all that apply.

☐ Peginterferon ☐ Ribavirin ☐ Daklinza ☐ Patient is interferon intolerant to or has contraindication

G. Does the patient have liver cirrhosis?

☐ Yes
  ☐ Compensated
  ☐ Decompensated
☐ No

H. Does the patient have hepatocellular carcinoma awaiting liver transplantation?

☐ Yes ☐ No

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Sovaldi likely be the most effective option for this patient?
☐ Yes ☐ No
If yes, please explain why: _____

All fields must be complete and legible for review. Your office will receive a response via fax.
Updated 01/2018
Last reviewed 09/2018

If the patient is currently using Sovaldi, would changing the patient's current regimen likely result in adverse effects for the patient?

☐ Yes ☐ No

If yes, please explain: _____

_____

_____

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 01/2018
Last reviewed 09/2018