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 _____

Prior authorization criteria

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.

For this drug to be covered, the patient must meet the following criteria:

1. Must be used for a medically accepted indication*
2. Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist
3. Must be age 3 or over
4. Criteria will be applied consistent with current AASLD/IDSA guidance

Additional information

Note: Criteria for duration of coverage will be applied consistent with current AASLD/IDSA guidance

All fields must be complete and legible for review. Your office will receive a response via fax.
Updated 01/2020
Last reviewed 01/2020

PriorityHealth

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. Does the patient have liver cirrhosis?

☐ Yes
  ☐ Compensated
  ☐ Decompensated
☐ No

E. Has the patient had a liver transplant?

☐ Yes ☐ No

F. Does the patient have a co-infection with HIV?

☐ Yes ☐ No

G. What is the patient's current pre-treatment HCV RNA? _____ IU/mL

Priority Health Medicare Exception Request *(exceptions to the above criteria)*

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: _____

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: _____

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