AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Vosevi

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 28 Days: 28
11. Length of Therapy: ___12 weeks

Clinical Information

1. Is the beneficiary 18 years of age or older with a diagnosis of chronic Hepatitis C (CHC) infection with confirmed genotype 1, 2, 3, 4, 5, or genotype 6 without cirrhosis or with compensated cirrhosis? Yes___ No___
Genotype is: _____ **Child-Pugh Grade**: _____
2. Has the beneficiary previously been treated with an HCV regimen containing an NS5A inhibitor and have a genotype of 1, 2, 3, 4, 5, or 6; or has the beneficiary previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor and has a genotype of 1a or genotype 3? Yes___ No___
3. As the provider, are you reasonably certain that treatment will improve the beneficiary's overall health status? Yes___ No___
4. Does the beneficiary have an FDA-labeled contraindication to Vosevi? Yes___ No___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406