

Pharmacy Request for Prior Approval – Vosevi

8. Beneficiary ID #:		2. First Name:		
6. Prescriber Name: NPI #: TIPE 6. Prescriber Name: NPI #: TIPE 7. Requester Contact Information: Phone #: Fax #: 7. Requester Contact Information 8. Drug Name: 9. Strength: 10. Quantity Per 28 Days: 28. 7. Length of Therapy: 12 weeks 8. In Length of Therapy: 12 weeks 8. Strip No Strength: 10. Quantity Per 28 Days: 28. 9. Strength: 10. Quantity Per 28 Days: 28. 11. Length of Therapy: 12 weeks 8. Strip No Strength: 10. Quantity Per 28 Days: 28. 12. Strip No Strength: 10. Quantity Per 28 Days: 28. 13. Strip Per 28. Days: 28. 14. Strip No Strength: 10. Quantity Per 28 Days: 28. 15. Strip No Strength: 10. Quantity Per 28 Days: 28. 16. Length of Therapy: 12. Weeks 17. Strip No 10. Quantity Per 28 Days: 28. 17. Strip No 10. Quantity Per 28 Days: 28. 18. The beneficiary for Strip No 10. Quantity Per 28 Days: 28. 19. Strip No 10. Quantity Per 28 Days: 28. 19. Strip No 10. Quantity Per 28 Days: 28. 10. Quantity Per 28 Days: 28. 11. Length of Therapy: 10. Quantity Per 28 Days: 28. 12. Strip No 10. Quantity Per 28 Days: 28. 13. Strip Per 28 Days: 28. 14. Strip No 10. Quantity Per 28 Days: 28. 15. Strip No 10. Quantity Per 28 Days: 28. 16. Strip No 10. Quantity Per 28 Days: 28. 17. Strip No 10. Quantity Per 28 Days: 28. 18. Strip No 10. Quantity Per 28 Days: 28. 19. Strip No 10. Quantity Per 28 Days: 28. 19. Strip No 10. Quantity Per 28 Days: 28. 10. Quantity Per 28 Days: 28. 11. Length of Therapy: 10. Quantity Per 28 Days: 28. 12. Strip No 10. Quantity Per 28 Days: 28. 13. Strip Per 28 Days: 28. 14. Strip No 29.	3. Beneficiary ID #:	4. Beneficiary Date of Birth:	5. Beneficiary Gender:	
6. Prescriber Name:	Droccribor Information			
Mailing address:		NIPI #·		
7. Requester Contact Information: Name: Phone #: Fax #: Proug Information	Mailing address:	Citv:	State: ZIP:	
8. Drug Name:				
8. Drug Name:	Name:	Phone #:	Fax #:	
8. Drug Name:	Drug Information			
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:	8. Drug Name:	9. Strenath:	10. Quantity Per 28 Days: <u>28</u>	
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*Prescriber signature mandatory		Date	:	
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	*Prescriber signature mandatory	complete to the best of my knowledge a	and Lundorstand that any falcification, omission, or consealment of	

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

material fact may subject me to civil or criminal liability.