FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Epclusa® & sofosbuvir/velpatasvir Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Chronic Hepatitis C

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Document the patient's hepatitis C virus (HCV) genotype:* _____

Will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has a diagnosis of chronic hepatitis C virus genotype 1, 2, 3, 4, 5, or 6?* ❑ **Yes** ❑ **No**

**Please note: Chart documentation of the above is required to be submitted along with this fax.*

Select if Epclusa (sofosbuvir/velpatasvir) is prescribed by or in consultation with one of the following:

❑ Gastroenterologist ❑ HIV specialist

❑ Hepatologist ❑ Infectious disease specialist

Will the patient be receiving Epclusa (sofosbuvir/velpatasvir) in combination with another HCV direct acting anti-viral agent [e.g., Sovaldi (sofosbuvir), Olysio (simeprevir)]? ❑ **Yes** ❑ **No**

Does the patient have decompensated liver disease? ❑ **Yes** ❑ **No**

Will Epclusa (sofosbuvir/velpatasvir) be used in combination with ribavirin? ❑ **Yes** ❑ **No**

Is the patient ribavirin intolerant or ineligible? ❑ **Yes** ❑ **No**

Will Epclusa (sofosbuvir/velpatasvir) be used alone (monotherapy)? ❑ **Yes** ❑ **No**

Does the patient have prior failure (defined as viral relapse, breakthrough while on therapy, or non-responder therapy) to Sovaldi or NS5A-based treatment? ❑ **Yes** ❑ **No**

For generic sofosbuvir/velpatasvir requests, also answer the following:

Select if the patient has had trial and failure, contraindication, or intolerance to the following:

❑ Brand Harvoni (ledipasvir/sofosbuvir)

❑ Mavyret (glecaprevir/pibrentasvir)

Has the patient had trial and failure or intolerance to Brand Epclusa? ❑ **Yes** ❑ **No**

If "no" to the above question, is the patient already receiving generic therapy? ❑ **Yes** ❑ **No**

Is this request for continuation of prior generic sofosbuvir/velpatasvir? ❑ **Yes** ❑ **No**

Epclusa® & sofosbuvir/velpatasvir Prior Authorization Request Form (Page 2 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Quantity Limit Requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.