PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Sovaldi - Medicare Part D - No Auto-Approvals

Phone: 800-728-7947 **Fax back to: 866-880-4532**

Scott & White Prescription Services manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. For what diagnosis is the drug being prescribed (pick one)?

☐ Chronic Hepatitis C ☐ Other

Q2. Please provide ICD code(s) for diagnosis.

Q3. Please indicate genotype of the patient.

☐ Genotype 1a
☐ Genotype 1b
☐ Genotype 2
☐ Genotype 3
☐ Genotype 4
☐ Genotype 5
☐ Genotype 6

Q4. Does the patient have cirrhosis?

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☐ Yes ☐ No

Q5. Please indicate practicing specialty of the prescribing physician.

☐ Board Certified Hepatologist
☐ Board Certified Infectious Disease
☐ Board Certified Gastroenterologist
☐ Other

Q6. Is the patient greater than or equal to 18 years of age?

☐ Yes ☐ No

Q7. Please specify which regimen the patient will be taking.

☐ Sovaldi, peg-interferon alfa, and ribavirin - 12 weeks
☐ Sovaldi and ribavirin - 12 weeks
☐ Sovaldi and ribavirin - 24 weeks
☐ Sovaldi and Olysio (with or without ribavirin) - 12 weeks
☐ Sovaldi and ribavirin - 48 wks (or until transplant)
☐ Other (please specify: drugs, dosages, directions, and duration of treatment)

Q8. Is the patient TREATMENT NAIVE? [Per AASLD guidelines, treatment naive patients are those that have NEVER BEEN TREATED or those that have RELAPSED after prior therapy.]

☐ Yes ☐ No

Q9. Is the patient TREATMENT EXPERIENCED? [Treatment experienced includes null or partial responders to prior therapy. SPECIFY ALL MEDICATIONS PREVIOUSLY TRIED.]

☐ Yes ☐ No

Q10. Does the patient have hepatocellular carcinoma (HCC) meeting MILAN criteria (awaiting liver transplantation)?

☐ Yes ☐ No

Q11. Is the patient interferon ineligible (i.e. Interferon therapy is contraindicated due to a condition such as anemia, alcohol abuse, advanced cirrhosis, or severe psychiatric disorder)?

☐ Yes ☐ No

Q12. Is the patient interferon intolerant (i.e. discontinued interferon therapy prematurely due to side effects)?

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☐ Yes ☐ No

Q13. Is the patient intolerant to ribavirin? [Please explain intolerance]

☐ Yes ☐ No

Q14. Additional Comments:

______________________________ Prescriber Signature

______________________________ Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

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