PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Medicare Part D - Sovaldi

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

The Scott & White Health Plan Pharmacy Department 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. What is the patient's diagnosis?

- ☐ Genotype 1a chronic HCV (or MIXED genotype 1a and 1b)
- ☐ Genotype 1b chronic HCV
- ☐ Genotype 2 chronic HCV
- ☐ Genotype 3 chronic HCV
- ☐ Genotype 4 chronic HCV
- ☐ Genotype 5 chronic HCV
- ☐ Genotpye 6 chronic HCV
- ☐ Other (please specify)

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

Q3. 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)

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☐ Other (please specify: drugs, dosages, directions, and duration of treatment)

Q4. Please indicate practicing specialty of the prescribing physician.

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

Q5. Is the patient greater than or equal to 12 years of age?

☐ Yes ☐ No

Q6. Select the status that applies to this patient and provide documentation to support selection.

☐ Clinically DECOMPENSATED cirrhosis
☐ Compensated cirrhosis
☐ No evidence of cirrhosis

Q7. Describe the patient's previous treatment history.

☐ Never been treated
☐ Relapsed
☐ Partial responder
☐ Null responder
☐ Treated but did not complete full course of therapy

Q8. Describe the patient's previous treatment history and include DRUG NAMES, DATES OF TREATMENT, LENGTH OF TREATMENT, OUTCOME / RESPONSE.

Q9. Has the patient had a liver transplant?

☐ Yes ☐ No

Q10. Additional Comments:

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_____ _____

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

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.