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NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for Sovaldi

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information –
Name: _____ Phone #: _____ Ext._____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ 12 Weeks ☐ 24 Weeks ☐ 48 Weeks

Clinical Information

Total Length of Therapy (Check ONE):
☐ **12 weeks =** Genotype 1, 2, or 4 for treatment-naïve and treatment-experienced adult beneficiaries without cirrhosis or with compensated cirrhosis (child-pugh A); or genotype 2 for treatment-naïve and treatment-experienced pediatric patients, 3 years of age or older, without cirrhosis or with compensated cirrhosis (child-pugh A). Genotype 1 and previously treated with a regimen containing an NS3/4A PI_2 without prior treatment with an NS5A inhibitor
☐ **24 weeks** = Genotype 1 adult beneficiaries that are PEG-interferon ineligible; genotype 3 for treatment-naïve and treatment experienced adults without cirrhosis or with compensated cirrhosis (child-pugh A); Or genotype 3 for treatment-naïve and treatment-experienced pediatric patients, 3 years of age or older, without cirrhosis or with compensated cirrhosis (child-pugh A)
☐ **48 weeks =** Genotype 1,2,3, or 4 for adult beneficiaries with a diagnosis of Hepatocellular Carcinoma awaiting liver transplantation (up to 48 weeks or until liver transplantation, whichever comes first)

1. Does the beneficiary have a diagnosis of chronic hepatitis C infections with one of the following confirmed diagnosis':
   ☐ Genotype 1 or 4 without cirrhosis or with compensated cirrhosis and beneficiary is 18years of age or older
   ☐ Genotype 2 or 3 without cirrhosis or with compensated cirrhosis and beneficiary is 3 years of age or older
   ☐ Beneficiary has CHC infection with hepatocellular carcinoma awaiting liver transplant
2. Are medical records documenting the diagnosis of chronic hepatitis C with genotype and subtype being submitted with this request? ☐ **Yes** ☐ **No** ****Lab test results MUST be attached to the PA to be approved.****
3. Does the beneficiary have a documented quantitative HCV RNA at baseline that was tested within the past 6 months (medical documentation required)? ☐ **Yes** ☐ **No HCN RNA (IU/ml): _____ and/or log10 value: _____**
4. As the provider, are you reasonably certain that treatment will improve the beneficiary's overall health status?
   ☐ **Yes** ☐ **No**
5. Is Sovaldi being prescribed in combination with ribavirin and pegylated interferon alfa for genotypes 1 and 4?
☐ **Yes** ☐ **No**
6. Is Sovaldi being prescribed in combination with ribavirin for beneficiaries with genotype 1 who are peginterferon-ineligible (medical record documentation of previous peginterferon therapy or reason for ineligibility must be submitted for review)? ☐ **Yes** ☐ **No**
7. Is Sovaldi being prescribed in combination with ribavirin for genotypes 2 and 3 and/or in CHC beneficiaries with hepatocellular carcinoma awaiting liver transplant? ☐ **Yes** ☐ **No**
8. Is Sovaldi being used as monotherapy? ☐ **Yes** ☐ **No**

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9. Is Sovaldi being used with any other sofosvuvir containing regimen? ☐ **Yes** ☐ **No**
10. Does the beneficiary have any FDA labeled contraindications to sofosbuvir (Sovaldi)? ☐ **Yes** ☐ **No**
11. Is the beneficiary pregnant? ☐ **Yes** ☐ **No**
12. Does the beneficiary have severe renal impairment (CrCl less than 30 mL/min), end stage renal disease, or require dialysis (AASLD/IDSA 2014)? ☐ **Yes** ☐ **No**
13. Is the beneficiary a non-responder to sofosbuvir? ☐ **Yes** ☐ **No**
14. Has the beneficiary previously failed therapy with a treatment regimen that included sofosbuvir? ☐ **Yes** ☐ **No**
15. Does the beneficiary have hepatocellular carcinoma and is not awaiting a liver transplant? ☐ **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.

Please fax this form to **1-800-678-3189** Pharmacy PA Call Center: **1-866-799-5318**