



**NC Medicaid
Pharmacy Prior Approval Request for
Vosevi**

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: 28
11. Length of Therapy (in days): 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 contraindications to Vosevi? 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.

Fax this form to (800) 678-3189

Pharmacy PA Call Center: (866) 799-5318