NC Medicaid and NC Health Choice
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. 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.****
4. Does the beneficiary have a documented quantitative HCV RNA at baseline that was tested within the past 6 months (medical documentation required)? ☐ **Yes** ☐ **No HCV RNA (IU/ml): _______ and/or log10 value: _______**
5. As the provider, are you reasonably certain that treatment will improve the beneficiary's overall health status?
   ☐ **Yes** ☐ **No**
6. 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.

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

©WellCare 2021