



Vosevi Prior Authorization Form

Recipient Information

1. Recipient Last Name#: _____ 2. First Name#: _____
3. Recipient ID #: _____ 4. Recipient Date of Birth: ___/___/___ 5. Recipient Gender: _____

Prescriber Information

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

Drug Information

8. Drug Name: Vosevi 9. _____ Per 28 Days
10. Total Length of Therapy (Check ONE):
___ 12 weeks = All genotypes previously treated with an HCV regimen containing an NS5A inhibitor

*only 8 weeks can be approved with this form. Must use continuation form to request last 4 weeks.
List previous med tried: _____

___ 12 weeks = Genotypes 1a or 3 previously treated with an HCV regimen containing Sofosbuvir without an NS5A

*only 8 weeks can be approved with this form. Must use continuation form to request last 4 weeks.
List previous med tried: _____

Clinical Information

- 1. The patient readiness to treat form is filled out and signed by the patient: YES or NO (circle one)*
2. The Child-Pugh Grade is: _____ (see Hepatitis-C Clinical Criteria)
3. The Genotype is: _____ *
4. HCV-RNA (IU/ML) _____ and/or log10 value _____ (must be within last 6 months) *
5. Fibrosis stage _____ (see Hepatitis-C Clinical Criteria) *

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.

Readiness to treat form and actual lab test results (NOT PROGRESS NOTES) MUST be attached to the PA to be approved.

Fax this form to: (800) 678-3189 Pharmacy PA Call Center: (866) 799-5318