Sovaldi (Sofosbuvir)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

Continued on next page.

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Chronic hepatitis C virus (HCV) ☐ Other Diagnosis_____ICD-10 Code(s):_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:
Select from the following which drug regimen is being used to treat the patient's HCV infection during this course of treatment:
☐ **Sovaldi + ribavirin (RBV) + peginterferon**
☐ **Sovaldi + RBV**
☐ **Sovaldi + Olysio with or without RBV**
☐ **Other: _____**

Document the patient's genotype: _____

<u>For Sovaldi + RBV:</u>
Does the patient have hepatocellular carcinoma that meets Milan criteria? ☐ Yes ☐ No

Is the patient waiting for a liver transplant? ☐ Yes ☐ No

Select if the patient has an intolerance or contraindication to peg-interferon therapy, demonstrated by the following characteristics:*
- ☐ **Intolerance to IFN**
- ☐ **Autoimmune hepatitis and other autoimmune disorders**
- ☐ **Hypersensitivity to PEG or any of its comp**
- ☐ **Decompensated hepatic disease**
- ☐ **Major uncontrolled depressive illness**
- ☐ **A baseline neutrophil count below 1500/µL, a baseline platelet count below 90,000/µL or baseline hemoglobin below 10g/dL**
- ☐ **A history of preexisting cardiac disease**

Please provide documentation.

Has the patient tried and had an inadequate response to prior HCV treatment (prior non-responder)? ☐ Yes ☐ No

<u>For Sovaldi + Olysio with or w ithout RBV:</u>
Select which of the follow ing scenario best describes the patient:
- ☐ **Treatment-naïve**

□ **Non-responder to prior treatment***

Must provide documentation including treatment dates, response rates and lab reports.

If treatment naïve, select if the patient has an intolerance or contraindication to peg-interferon therapy, demonstrated by the following characteristics:*

□ **Intolerance to IFN**
□ **Autoimmune hepatitis and other autoimmune disorders**
□ **Hypersensitivity to PEG or any of its components**
□ **Decompensated hepatic disease**
□ **Major uncontrolled depressive illness**
□ **A baseline neutrophil count below 1500/µL, a baseline platelet count below 90,000/µL or baseline hemoglobin below 10g/dL**
□ **A history of preexisting cardiac disease**

Please provide documentation

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909