

## Vosevi (sofosbuvir; velpatasvir; voxilaprevir) 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.

MEMBER INFORMATION					
LAST NAME:		FIRST NAME:			
PHONE NUMBER:		DATE OF BIRTH:			
STREET ADDRESS:					
CITY:	STATE: ZIP CODE:				
PATIENT INSURANCE ID NUN	MBER:				
MALE FEMALE HEIG	GHT (IN/CM): WEIGH	HT (LB/KG):	ALLERGII	ES:	
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):					
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	IF RENEWAL: DATE T	HERAPY	INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):					

Continued on next page.



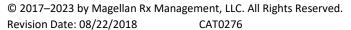


## Vosevi (sofosbuvir; velpatasvir; voxilaprevir) Prior Authorization Request Form



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

MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:		
1. HAS THE PATIENT TRIED ANY OTHER	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) 🔲 NO	
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	<b>DURATION OF THERAPY</b> (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:	
2. LIST DIAGNOSES:		ICD-10:	
□ Chronic hepatitis C virus (HCV) □ Other diagnosis:			
<b>3. REQUIRED CLINICAL INFORMATION:</b> PRIOR AUTHORIZATION.	: PLEASE PROVIDE ALL RELEVANT CLINICA	AL INFORMATION TO SUPPORT A	
Clinical Information: Document the patient's chronic hepat	itis C virus genotype:		
Does the patient have cirrhosis? ☐ Yes	□ <b>No</b>		
Does the patient have compensated liv	ver disease (Child-Pugh class A)? 🗆 Yes	□ No	
Has the patient been previously treate Daklinza, Harvoni, Viekira, Zepatier or	ed with a HCV regimen containing an NS Epclusa?   Yes   No	5A inhibitor such as those included in	
Has the patient been previously treate Harvoni, Viekira, Zepatier or Epclusa?	ed with Sovaldi without an NS5A inhibito □ Yes □ No	or such as those included in Daklinza,	
Is Vosevi prescribed by a hepatologist,	gastroenterologist, or infectious diseas	e specialist?   Yes   No	
• • • • •	ed with an HCV regimen containing sofo, Viekira, Zepatier or Epclusa?*   Yes   with dates of service.		
Are there any other comments, diagnor physician feels is important to this rev	oses, symptoms, medications tried or fa iew?	iled, and/or any other information the	
<b>Please note:</b> Not all drugs/diagnosis are information is received.	e covered on all plans. This request may	be denied unless all required	
the Health Plan, insurer, Medical Group	provided is true and accurate to the best or its designees may perform a routine uracy of the information reported on thi	audit and request the medical	
Prescriber Signature or Electronic L.D.	Verification:	Date:	









## Vosevi (sofosbuvir; velpatasvir; voxilaprevir) Prior Authorization Request Form



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

**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**FAX THIS FORM TO: 800-424-7640** 

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP – 4201 P.O. Box 64811 St. Paul, MN 55164-0811

