PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS
Vosevi - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Vosevi - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Vosevi (sofosbuvir-velpatasvir-voxilaprevir)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Does the patient have a diagnosis of chronic hepatitis C? Y N

NOTE: Submission of medical records is required.

[If no, no further questions.]

2. Has the patient had a hepatitis C infection for 6 months or greater? Y N

[If no, no further questions.]

3.	Has chronic disease been supported by one of the following: A) lab testing such as an HCV antibody or HCV RNA test completed 6 months apart, B) HCV diagnosis documented in prescribers' note from the past office visit(s), or C) exposure risk history documented in prescribers' notes from the past office visit(s)?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
4.	Has the patient's genotype and subtype been determined?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
5.	Has the patient undergone a liver biopsy or another accepted test that has demonstrated a liver fibrosis status?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
6.	Does the patient have a diagnosis of cirrhosis?	Y N
	NOTE: Submission of medical records is required.	
	[If no, skip to question 9.]	
7.	Has clinical documentation showing support for the diagnosis, prior hepatitis C treatment history, and treatment response (Relapsed, Partial Responder, Non-Responder, Toxicity, or Reinfection), and a planned treatment been submitted and dated within 90 days of the prior authorization request?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
8.	Does the patient have baseline laboratory values including HCV RNA level, total bilirubin, albumin, and INR within 90 days of prior authorization request?	Y N
	NOTE: Submission of medical records is required.	
	[If yes, skip to question 11.]	
	[If no, no further questions.]	
9.	Has clinical documentation showing support for the diagnosis, prior hepatitis C treatment history, and treatment response (Relapsed, Partial Responder, Non-Responder, Toxicity, or Reinfection), and a planned treatment been submitted and dated within 180 days of the prior authorization request?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
10.	Does the patient have baseline HCV RNA level within 180 days of prior authorization request?	Y N
	NOTE: Submission of medical records is required.	

[If no, no further questions.]		
11. Is the patient human immunodeficiency virus (HIV) positive?	Y N	
[If no, skip to question 13.]		
12. Has the patient's current antiretroviral regimen and degree of viral suppression been documented within 180 days prior to the request?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
13. Does the patient have active hepatitis B virus (HBV) disease?	Y N	
[If no, skip to question 15.]		
14. Has the patient's current antiretroviral regimen and degree of viral suppression been documented within 180 days prior to the request?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
15. Has a treatment plans been developed and discussed with the patient?	Y N	
[If no, no further questions.]		
16. Is the patient 18 years of age or older?	Y N	
[If no, no further questions]		
17. Has the patient had trial and failure of a previous hepatitis C treatment regimen containing an NS5A inhibitor (e.g., Mavyret, Harvoni, Zepatier, Epclusa) or sofosbuvir without an NS5A inhibitor?	Y N	
[If no, no further questions.]		
18. Is the requested duration of therapy greater than 12 weeks of treatment?	Y N	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date