

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

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 a	asworfor each question				
	-				
	a diagnosis of chronic hepatitis C?	YN			
NOTE: Submission	of medical records is required.				
[If no, no further questions.]					
2. Has the patient's geno	otype and subtype been determined?	Y N			
NOTE: Submission	of medical records is required.				
[If no, no further que	estions.]				

3.	Has the patient undergone a liver biopsy or another	Y	Ν]		
	accepted test that has demonstrated a liver fibrosis status?					
	NOTE: Submission of medical records is required.					
	[If no, no further questions.]					
4.	Does the patient have a diagnosis of cirrhosis?	Y	Ν			
	NOTE: Submission of medical records is required.					
	[If no, skip to question 7.]					
5.	Has clinical documentation showing support for the diagnosis, prior hepatitis C treatment history, and 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.]					
6.	Does the patient have baseline laboratory values including HCV RNA level within 90 days of prior authorization request?	Y	N]		
	NOTE: Submission of medical records is required.					
	[If yes, skip to question 9.]					
	[If no, no further questions.]					
7.	Has clinical documentation showing support for the diagnosis, prior hepatitis C treatment history, and 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.]					
8.	Does the patient have baseline laboratory values including HCV RNA level within 180 days of prior authorization request?	Y	N]		
	NOTE: Submission of medical records is required.					
	[If no, no further questions.]					
9.	Is the patient HIV positive?	Y	Ν]		
	[If no, skip to question 11.]					
10.	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.]					
11.	Does the patient have active HBV disease?	Y	Ν]		
	[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. Has a consult been performed and medication prescribed by a provider specializing in infectious disease, gastroenterology, hepatology or Hepatitis C?	Y N			
[If no, no further questions.]				
14. Has a treatment plan been developed for the patient in collaboration with a physician with expertise in Hepatitis C management?	Y N			
NOTE: Submission of medical records is required.				
[If no, no further questions.]				
15. Has the patient been prescribed a ribavirin-containing regimen?	Y N			
[If no, skip to question 18.]				
16. Is the patient or their partner of childbearing age?	Y N			
[If no, skip to question 18.]				
17. Is she utilizing 2 forms of contraception for the duration of therapy, as well as for 6 months post-treatment?	Y N			
[If no, no further questions.]				
18. Is the request for Vosevi?	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