

TRICARE Prior Authorization Request Form for
Sofosbuvir/Velpatas/Voxilaprev (**Vosevi**), sofosbuvir (**Sovaldi**)



JOHNS HOPKINS
HEALTH PLANS

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**FAX Completed Form and
Applicable Progress Notes to:
(410) 424-4037**

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorizations will expire in 1 year. PA must be resubmitted.

Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID #: _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Please indicate which medication is being prescribed: _____

Step 2 Please complete the clinical assessment:

1. Is the requested medication prescribed by a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 2
2. Is the requested medication prescribed in consultation with a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Does the patient have a detectable hepatitis C viral load?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. Is the requested medication for retreatment of hepatitis C virus (HCV) that has failed treatment with a regimen containing an NS5A inhibitor (for example, daclatasvir, elbasvir, ledipasvir, ombitasvir, pibrentasvir, or velpatasvir)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 5

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5. Is the requested medication for retreatment of hepatitis C virus (HCV) that has failed treatment with a regimen containing sofosbuvir with or without an NS5A inhibitor (for example, daclatasvir, elbasvir, ledipasvir, ombitasvir, pibrentasvir, or velpatasvir)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
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Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature

Date

[08 January 2025]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: