Prior Authorization Request Form for
Sofosbuvir/ Velpatasvir/voxilaprevir (Vosevi)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

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

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.

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

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

Step 2 **Please complete the clinical assessment:**

1. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question 2	☐ No **STOP** **Coverage not approved**
2. Does the patient have laboratory evidence of chronic hepatitis C virus (HCV)?	☐ Yes Proceed to question 3	☐ No **STOP** **Coverage not approved**
3. Is Vosevi prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician?	☐ Yes Proceed to question 4	☐ No **STOP** **Coverage not approved**
4. Has the patient received previous treatment with a HCV regimen containing a NS5A Inhibitor (for example, daclatasvir, elbasvir, ledipasvir, ombitasvir, pibrentasvir, or velpatasvir)?	☐ Yes Proceed to question 6	☐ No Proceed to question 5
5. Has the patient received previous treatment with a HCV regimen containing sofosbuvir AND has Hepatitis C Genotype 1a or 3 (for example: Harvoni, Epclusa or Sovaldi)?	☐ Yes Proceed to question 6	☐ No **STOP** **Coverage not approved**
6. What is the HCV genotype?	☐ **Genotype 1a -** Proceed to question 7 ☐ **Genotype 1b or other genotype 1 subtype -** Proceed to question 7 ☐ **Genotype 2 -** Proceed to question 7 ☐ **Genotype 3 -** Proceed to question 7 ☐ **Genotype 4 -** Proceed to question 7 ☐ **Genotype 5 -** Proceed to question 7 ☐ **Genotype 6 -** Proceed to question 7 ☐ **All others - STOP Coverage not approved**	

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7. Does the patient does have an estimated glomerular filtration rate (eGFR) less than or equal to 30mL/min or end-stage renal disease (ESRD) requiring hemodialysis?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question 8
8. Will the patient be receiving concomitant therapy with other hepatitis C drugs or rifampin?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question 9
9. Will the course of treatment exceed the maximum duration of treatment of 12 weeks?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

_____ _____
Prescriber Signature Date

[2 January 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: