

**State of Oklahoma
Oklahoma Health Care Authority
Sovaldi™ Initiation Prior Authorization Form**

Member Name: _____ **Date of Birth:** _____ **Member ID#:** _____
Pharmacy NPI: _____ **Pharmacy Phone:** _____ **Pharmacy Fax:** _____
Pharmacy Name: _____ **Pharmacist Name:** _____
Prescriber NPI: _____ **Prescriber Name:** _____ **Specialty:** _____
Prescriber Phone: _____ **Prescriber Fax:** _____ **Drug Name:** _____
NDC: _____ **Start Date:** _____

Clinical Information

1. HCV Genotype (including subtype): _____ Date Determined: _____
2. METAVIR Equivalent Fibrosis Stage: _____ Testing Type: _____
Date Fibrosis Stage Determined: _____
3. Pre-Treatment Viral Load: _____ Date Determined: _____
4. Does member have decompensated hepatic disease (CTP class B or C)? Yes ___ No ___
5. Has the member been evaluated by a gastroenterologist, infectious disease specialist, or a transplant specialist within the past 3 months? Yes ___ No ___
6. If yes, please include name of specialist recommending hepatitis C treatment: _____
7. Has the member been previously treated for hepatitis C? Yes ___ No ___
8. If yes, please indicate previous treatment regimen and reason for failure (relapser, null-responder, partial responder): _____
9. Please indicate regimen below (if member is IFN ineligible please specify reasoning):
 - Sovaldi™ plus RBV plus weekly PEG/IFN 12 weeks
 - Sovaldi™ plus RBV 12 weeks
 - Sovaldi™ plus RBV 16 weeks
 - Sovaldi™ plus RBV 24 weeks
 - Sovaldi™ plus Daklinza™ 12 weeks ***Must also submit Daklinza™ Initiation Prior Authorization Form*
 - Sovaldi™ plus Daklinza™ and RBV 12 weeks ***Must also submit Daklinza™ Initiation Prior Authorization Form*
 - Other: _____
(if also requesting Olysio®, the Olysio® Initiation Prior Authorization Form will also need to be submitted)
10. Has the member signed the intent to treat contract**? Yes ___ No ___ ***Required for processing of request.*
11. Has the member had illicit IV drug use or alcohol abuse in the last 6 months? Yes ___ No ___
12. Has the member initiated immunization with the hepatitis A and B vaccines? Yes ___ No ___
13. For women of childbearing potential (and male patients with female partners of childbearing potential):
 - Patient is not pregnant (or a male with a pregnant female partner) and not planning to become pregnant during treatment or within 6 months of completing treatment
 - Agreement that partners will use two forms of effective non-hormonal contraception during treatment and for at least 6 months after completing treatment. Please list non-hormonal birth control options discussed with member _____
 - Verification that monthly pregnancy tests will be performed throughout treatment for ribavirin users
14. Is the member taking any of the following medications: amiodarone, rifampin, rifabutin, rifapentine, carbamazepine, eslicarbazepine, phenytoin, oxcarbazepine, tipranavir/ritonavir, didanosine or St. John's wort? Yes ___ No ___
15. Have all other clinically significant issues been addressed prior to starting therapy? Yes ___ No ___

I recommend this patient be followed by an OHCA Care Management Nurse.

Members must be adherent for continued approval. Treatment gaps of therapy longer than 3 days will result in denial of payment for subsequent requests for continued therapy. Refills must be prior authorized.

Prescriber Signature: _____ **Date:** _____

Has the member been counseled on appropriate use of Sovaldi™ therapy? Yes ___ No ___

Pharmacist Signature: _____ **Date:** _____

Please do not send in chart notes. Specific information/documentation will be requested if necessary. Failure to complete this form in full will result in processing delays.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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