

Eplclusa® (Sofosbuvir/Velpatasvir) 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 if applicable): _____ 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. Does the member have severe renal impairment (estimated eGFR <30mL/min/m² ? Yes ___ No ___
6. Has the member been evaluated by a gastroenterologist, infectious disease specialist, or a transplant specialist within the past 3 months? Yes ___ No ___
7. If yes, please include name of specialist recommending hepatitis C treatment: _____
8. Has the member been previously treated for hepatitis C? Yes ___ No ___
9. If yes, please indicate previous treatment regimen and reason for failure (relapser, null-responder, partial responder): _____
10. Please indicate requested regimen below:
 - Eplclusa® 400mg/100mg daily x 84 days (12 weeks)
 - Eplclusa® 400mg/100mg daily with weight-based ribavirin x 84 days (12 weeks)
 - Other: _____ **

***Please supply reference citation to support requested therapy.*
11. Has the member signed the intent to treat contract**? Yes ___ No ___ ***Required for processing of request*
12. Has the member had illicit IV drug use or alcohol abuse in the last 6 months? Yes ___ No ___
13. Has the member initiated immunization with the hepatitis A and B vaccines? Yes ___ No ___
14. 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
 - Agreement that partners will use two forms of effective non-hormonal contraception during treatment (and for six months after therapy completion for those on ribavirin). Please list non-hormonal birth control options discussed with member _____
15. Is the member taking any of the following medications: H2-receptor antagonists at doses greater than 40mg famotidine equivalent, amiodarone, omeprazole or other proton pump inhibitors, topotecan, rifampin, rifabutin, rifapentine, carbamazepine, eslicarbazepine, phenytoin, phenobarbital, oxcarbazepine, efavirenz, tenofovir disoproxil fumarate, tipranavir/ritonavir and St. John's wort? Yes ___ No ___
16. If member is using antacids have they agreed to separate antacid and Eplclusa® administration by 4 hours? Yes ___ No ___ NA ___
17. Have all other clinically significant issues been addressed prior to starting therapy? Yes ___ No ___

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 Eplclusa® 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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