OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare
Sofosbuvir/Velpatasvir (Epclusa®)* Initiation Prior Authorization Form
***generic is preferred**

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:***_____ ***Start Date:***_____
Drug Name:_____ ***NDC:***_____ ***Member's Weight (kg):*** _____ ***Date Taken:***_____

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 in the last 12 months: _____ Date Taken: _____
   For METAVIR score of <F1, 2nd test must confirm chronic HCV diagnosis at least 6 months after 1st test.
   Prior pre-treatment viral load or antibody test: _____ Date Taken: _____
4. Does member have decompensated hepatic disease (CTP class B or C)? Yes☐ No☐
5. Is the member currently on hospice or does the member have a limited life expectancy (less than 12 months) that cannot be remediated by treating HCV? 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:
    - ☐ sofosbuvir/velpatasvir 400mg/100mg daily x 84 days (12 weeks)
    - ☐ sofosbuvir/velpatasvir 400mg/100mg daily with weight-based ribavirin x 84 days (12 weeks)
    - ☐ sofosbuvir/velpatasvir 200mg/50mg daily x 84 days (12 weeks)
    - ☐ sofosbuvir/velpatasvir 200mg/50mg daily with weight-based ribavirin x 84 days (12 weeks)
    - ☐ sofosbuvir/velpatasvir 150mg/37.5mg daily x 84 days (12 weeks)
    - ☐ sofosbuvir/velpatasvir 150mg/37.5mg daily with weight-based ribavirin x 84 days (12 weeks)
    - ☐ Other: _____
11. Has the member signed the intent to treat contract**? Yes☐ No☐ ***Required for processing of request* **
12. Has the member been counseled on the harms of illicit IV drug use and alcohol use? 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 2 forms of effective non-hormonal contraception during treatment (and for 6 months after therapy completion for those on ribavirin). Please list non-hormonal birth control options discussed with member _____
    - ☐ Verification that monthly pregnancy tests will be performed throughout treatment for ribavirin users
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, St. John's wort, or rosuvastatin doses exceeding 10mg? Yes☐ No☐
16. If member is using antacids have they agreed to separate antacid and sofosbuvir/velpatasvir 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 sofosbuvir/velpatasvir therapy? Yes☐ No☐
Pharmacist Signature: _____ **Date:** _____
Please do not send in chart notes. Failure to complete this form in full will result in processing delays. By signature, the prescriber or pharmacist confirms the above information is accurate.

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization throughCoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.