OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

SoonerSelect | aetna

Sovaldi® (Sofosbuvir) Initiation Prior Authorization Form

Member Name: _____ ***Date of Birth:*** _____ ***Member D#:*** _____
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 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 dosage form, strength, and regimen below:

- ☐ Sovaldi® 400mg tablets
- ☐ Sovaldi® 200mg tablets
- ☐ Sovaldi® 200mg oral pellets
- ☐ Sovaldi® 150mg oral pellets
- ☐ Other: _____

- ☐ once daily with weight-based ribavirin (RBV) and weekly peginterferon (PEG/IFN) x 84 days (12 weeks)
- ☐ once daily with RBV x 84 days (12 weeks)
- ☐ once daily with RBV x 112 days (16 weeks)
- ☐ once daily with RBV x 168 days (24weeks)

11. If member is interferon (IFN) ineligible, please specify reasoning: _____
12. Has the member signed the intent to treat contract**? Yes☐ No☐ ***Required for processing of request.***
13. Has the member been counseled on the harms of illicit IV drug use and alcohol use and agreed to not use illicit IV drugs or alcohol while on or after they finish hepatitis C treatment? Yes☐ No☐
14. Has the member initiated immunization with the hepatitis A and B vaccines? Yes☐ No☐
15. 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
16. 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☐
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 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. 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 through CoverMyMeds® 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.