NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

WellCare
Beyond Healthcare. A Better You.

Vosevi Prior Authorization Form

Recipient Information

1. Recipient Last Name#:__________________________ 2. First Name#:____________________________

3. Recipient ID #:_____________________4. Recipient Date of Birth: __/__/___ 5. Recipient Gender:_______

Prescriber Information

6. Prescribing Provider NPI#:#:_____________________

7. Requester Contact Information:

Name: ____Phone #:_____________________Ext::______

Drug Information

8. Drug Name:__**Vosevi**_ 9. ________ Per 28 Days

10. Total Length of Therapy **(Check ONE):**

___12 weeks = All genotypes previously treated with an HCV regimen containing an NS5A inhibitor

**only 8 weeks can be approved with this form. Must use continuation form to request last 4 weeks.*

List previous med tried: ____

____

___12 weeks = Genotypes 1a or 3 previously treated with an HCV regimen containing Sofosbuvir without an NS5A

**only 8 weeks can be approved with this form. Must use continuation form to request last 4 weeks.*

List previous med tried: ____

____

Clinical Information

1. The patient readiness to treat form is filled out and signed by the patient: **YES or NO (circle one)***
2. The Child-Pugh Grade is: ______ (see Hepatitis-C Clinical Criteria)
3. The Genotype is: _______*
4. HCV-RNA (IU/ML) ______ and/or log10 value ______ (must be within last 6 months) *
5. Fibrosis stage ______ (see Hepatitis-C Clinical Criteria) *

Signature of Prescriber: ______________________________________ Date: ________________
(Prescriber signature mandatory)
I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Readiness to treat form and actual lab test results (NOT PROGRESS NOTES) **MUST be attached to the PA to be approved.**

Fax this form to: (800) 678-3189 **Pharmacy PA Call Center: (866) 799-5318**