FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR SOVALDI™

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Sovaldi™ Completion Instructions, F-01247A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage* for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization Drug Attachment for Sovaldi™ form signed by the prescriber before submitting a prior authorization (PA) request on the Portal, by fax, or by mail. Providers may call Provider Services at (800) 947-9627 with questions.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number

3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION

4. Date Prescription Written

5. Directions for Use

6. Refills

7. Name — Prescriber

8. National Provider Identifier — Prescriber

9. Address — Prescriber (Street, City, State, ZIP+4 Code)

10. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION

11. Diagnosis Code and Description

12. Date Member Was Diagnosed with Hepatitis C

13. Indicate the member's hepatitis C virus (HCV) Genotype and subtype.

14. Is the member 18 years of age or older?	❑ Yes	❑ No
15. Is the member pregnant?	❑ Yes	❑ No
16. Has the member had a liver transplant?	❑ Yes	❑ No
17. Is the member on a liver transplant wait list?	❑ Yes	❑ No
18. Does the member have hepatocellular carcinoma?	❑ Yes	❑ No

19. Indicate the member's most recent hepatitis C virus ribonucleic acid (HCV-RNA) level and the date it was taken.

HCV-RNA _____ IU / mL Test Date _____

Continued

SECTION III — CLINICAL INFORMATION (Continued)

20. Indicate the member's proposed hepatitis C drug treatment regimen.

Drug Name _____ Daily Dose _____ Expected Duration _____
Currently taking? ❑ Yes ❑ No If yes, enter the date started. _____

Drug Name _____ Daily Dose _____ Expected Duration _____
Currently taking? ❑ Yes ❑ No If yes, enter the date started. _____

Drug Name _____ Daily Dose _____ Expected Duration _____
Currently taking? ❑ Yes ❑ No If yes, enter the date started. _____

21. Indicate the member's previous hepatitis C drug therapy or check "none" if appropriate.

❑ None

Drug Name _____ Daily Dose _____ Dates Taken _____
Drug Name _____ Daily Dose _____ Dates Taken _____
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Drug Name _____ Daily Dose _____ Dates Taken _____

22. List all non-hepatitis C drugs the member is currently receiving or check "none" if appropriate.

❑ None

Drug Name _____ Drug Name _____ Drug Name _____
Drug Name _____ Drug Name _____ Drug Name _____
Drug Name _____ Drug Name _____ Drug Name _____
Drug Name _____ Drug Name _____ Drug Name _____

23. Does the member have a history of alcohol abuse or illicit drug use? ❑ Yes ❑ No

If yes, provide details.

24. If the member has a history of alcohol abuse or illicit drug use, when did he or she last participate in alcohol abuse or illicit drug use? Provide documentation of at least six months of abstinence from alcohol abuse or illicit drug use.

25. If the member has a history of alcohol abuse or illicit drug use, is he or she currently participating in a recovery program, including counseling services, addiction specialist, and toxicology screening? ❑ Yes ❑ No

If yes, provide details.

Continued

SECTION III — CLINICAL INFORMATION (Continued)

26. Has the member had a liver biopsy? ❑ Yes ❑ No

    If yes, provide the date taken. _____

    Note: A copy of the results needs to be submitted with the PA request.

27. Has the member had a liver ultrasound or scan? ❑ Yes ❑ No

    If yes, provide the date taken. _____

    Note: A copy of the results needs to be submitted with the PA request.

28. If a Metavir score was calculated, provide the score, or write "None" if appropriate. (Scoring: 0 = No scarring; 1 = Minimal scarring; 2 = Scarring has occurred and extends outside the areas in the liver that contain blood vessels; 3 = Bridging fibrosis is spreading and connecting to other areas that contain fibrosis; 4 = Cirrhosis or advanced scarring of the liver.)

29. Does the member have cirrhosis of the liver? ❑ Yes ❑ No

    If yes, is the cirrhosis compensated? ❑ Yes ❑ No

    If yes, what was the member's most recent Child-Turcotte-Pugh Score? _____

30. Is the member coinfected with hepatitis A, hepatitis B, or Human Immunodeficiency Virus? ❑ Yes ❑ No

    If yes, list the coinfection(s).

31. Is the member a candidate for treatment with interferon alfa? ❑ Yes ❑ No

    If no, explain why the member is unable to take interferon alfa.

SECTION IV — AUTHORIZED SIGNATURE

32. **SIGNATURE —** Prescriber	33. Date Signed

SECTION V — ADDITIONAL INFORMATION

34. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.

Reset Form