BlueCross BlueShield Federal Employee Program.

SOVALDI
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Sovaldi (sofosbuvir)

NOTE: Form must be completed in its **entirety** for processing

Please select strength: ❑ **400mg Tablets** ❑ **200mg Tablets** ❑ **200 mg Pellets** ❑ **150mg Pellets**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. Does the patient have a diagnosis of hepatitis C? ❑Yes ❑No
2. Does the patient have a documented viral load (HCV RNA) from at least 6 months prior to this request for treatment? ❑Yes ❑No
3. Does the patient either have a poor prognosis and treatment cannot be delayed or have a past history where Hepatitis C infection is evident or suspected? ❑Yes ***(*If YES, please select answer below)*** ❑No
   ❑Poor prognosis and treatment cannot be delayed ❑Past history where Hepatitis C infection is evident or suspected
4. Does the patient currently have a viral load (HCV RNA) present in the serum? ❑Yes ❑No
5. Does the patient have a history of hepatitis B (HBV) infection? ❑Yes***** ❑No
   ****If YES***, does the prescriber agree to monitor for HBV reactivation? ❑Yes ❑No
6. Does the patient have hepatocellular carcinoma? ❑Yes***** ❑No
   ****If YES***, is the patient awaiting liver transplantation? ❑Yes ❑No
7. Does the patient have decompensated cirrhosis? ❑Yes ❑No
8. What is the patient's genotype? ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑Not tested / Unspecified / Unknown
9. Is the patient treatment naïve? ❑Yes ❑No*****
   ****If NO***, was the patient previously treated with one of the following therapies? ***Please select all that apply:***
   ❑Peginterferon ❑Peginterferon/Ribavirin ❑Other treatment ***(please specify)***: _____
10. Will Sovaldi be used in combination with peginterferon? ❑Yes ❑No
11. **If Genotype 1**: Is the patient interferon ineligible? ❑Yes ❑No
12. **Age 3-17**: What is the patient's weight? _____ kg **OR** _____ lbs
13. Will Sovaldi be used in combination with ribavirin? ***Please select answer below:***
    ❑**Yes**: Please answer the following questions:
    a. Does the patient have any significant or unstable cardiac disease? ❑Yes ❑No
    b. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes***** ❑No
    ****If YES***, will pregnancy be excluded before the start of treatment? ❑Yes***** ❑No
    ****If YES***, will the patient be advised to use effective contraception during treatment with ribavirin and for 6 months after the final dose? ❑Yes ❑No
    c. **MALE Patient**: Does the patient have a female partner of reproductive potential? ❑Yes***** ❑No
    ****If YES***, will pregnancy be excluded before the start of treatment? ❑Yes***** ❑No
    ****If YES***, will the patient be advised to use effective contraception during treatment with ribavirin and for 6 months after the final dose? ❑Yes ❑No
    ❑**No**: Is the patient ribavirin ineligible? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***