



**BlueCross  
BlueShield**

Federal Employee Program

**VOSEVI**

**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: <input type="checkbox"/> Male <input type="checkbox"/> Female			Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:	State:	Zip:		City:	State:	Zip:
Patient ID:	R			Physician Signature:		
<b>PHYSICIAN COMPLETES</b>						

**Vosevi**

(sofosbuvir, velpatasvir, voxilaprevir)

**\*\*Check [www.fepblue.org/formulary](http://www.fepblue.org/formulary) to confirm which medication is part of the patient's benefit**

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

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

- Does the patient have a diagnosis of hepatitis C? ☐ Yes ☐ No
- Does the patient have a documented viral load (HCV RNA) from at least 6 months prior to this request for treatment? ☐ Yes ☐ No
- 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, select one of the following below*) ☐ No
  - ☐ Poor prognosis and treatment cannot be delayed ☐ Past history where Hepatitis C infection is evident or suspected
- Does the patient currently have a viral load (HCV RNA) present in the serum? ☐ Yes ☐ No
- 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
- Does the patient have a diagnosis of cirrhosis? ☐ Yes\* (*If YES, please answer questions below*) ☐ No
  - Does the patient have a diagnosis of **decompensated** cirrhosis? ☐ Yes ☐ No
  - If Genotype 3:** Does the patient have a diagnosis of **compensated** cirrhosis? ☐ Yes ☐ No
- Has the patient had a kidney or liver transplant? ☐ Kidney transplant ☐ Liver transplant ☐ No
- If Kidney or Liver Transplant:** Was the patient previously treated with a \*Direct Acting Antiviral (DAA)? ☐ Yes ☐ No
  - \*DAAs: NS3/4A protease inhibitors, NS5A inhibitors, NS5B polymerase inhibitors*
- What is the patient's genotype? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Unknown genotype
- Is the patient treatment naïve? ☐ Yes ☐ No\*
  - If NO, was the patient previously treated with one of the following therapies? Please select answer below:*
    - ☐ NS5A inhibitor\* ☐ sofosbuvir (Sovaldi) ☐ Other therapy (please specify): \_\_\_\_\_
    - \*NS5A Inhibitors: daclatasvir (Daklinsa), elbasvir, ledipasvir, ombitasvir, pibrentasvir, velpatasvir*

11. Will Vosevi be used in combination with ribavirin? *Please select answer below:*

☐ Yes: Please answer the following questions:

- Does the patient have any significant or unstable cardiac disease? ☐ Yes ☐ No
- 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
- 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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Attached is a Prior Authorization request form.

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

<b>Electronically Online</b> (ePA) <b>Results in 2-3 minutes</b> <b>FASTEST AND EASIEST</b>	Now you can get responses to drug Prior Authorization requests <b>securely</b> online. <b>Online</b> submissions may receive <b>instant</b> 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 <b>Caremark.com/ePA</b> .
<b>Phone</b> (4-5 minutes for response)	The FEP Clinical Call Center can be reached at <b>(877)-727-3784</b> 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.
<b>Fax</b> (3-5 days for response)	Fax the attached form to <b>(877)-378-4727</b> . 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. <b><u>Please only fax the completed form once as duplicate submissions may delay processing times.</u></b>

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