BlueCross BlueShield Federal Employee Program.

ZEPATIER PRIOR APPROVAL REQUEST

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.

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

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					

For Standard Option patients Epclusa, Harvoni, Mavyret, and Sovaldi are a preferred regimen for Hepatitis C.
Standard Option patients who switch to a preferred regimen will be eligible for 2 copays at no cost in the benefit year.

❑Epclusa (Complete Page 3 ONLY)	**❑Mavyret (Complete Page 7 ONLY)**	**❑Vosevi (Complete Page 9 ONLY)**
❑Harvoni (Complete Pages 4 - 6 ONLY)	**❑Sovaldi (Complete Page 8 ONLY)**	

Zepatier

(elbasvir, grazoprevir)

****Check 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

1. Does the patient have a diagnosis of hepatitis C? ❑Yes ❑No
2. What is the patient's weight? _____ kg **OR** _____ lbs
3. Does the patient have a documented viral load (HCV RNA) from at least 6 months prior to this request for treatment? ❑Yes ❑No
4. 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 one of the following below)** ❑No
   ❑Poor prognosis and treatment cannot be delayed **OR** ❑Past history where Hepatitis C infection is evident or suspected
5. Does the patient currently have a viral load (HCV RNA) present in the serum? ❑Yes ❑No
6. Does the patient have decompensated cirrhosis? ❑Yes ❑No
7. Does the patient have severe hepatic impairment (Child-Pugh Class B or C)? ❑Yes ❑No
8. Has the patient had a liver transplant or waiting for a liver transplant? ❑Yes ❑No
9. 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
10. What is the patient's genotype? ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑Not tested / Unspecified / Unknown
11. **If Genotype 1:** What is the patient's subtype of genotype 1: ❑Subtype 1a ❑Subtype 1b ❑Other subtype / Unknown
12. **If Genotype Subtype 1a**: Has the patient been tested for the NS5A resistance-associated polymorphisms? ❑Yes***** ❑No
    If YES, is the patient positive for NS5A polymorphisms? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL ZEPATIER QUESTIONS

BlueCross BlueShield Federal Employee Program.

ZEPATIER PRIOR APPROVAL REQUEST

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Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

13. Is the patient treatment naïve? ❑Yes ❑No*****

If NO, was the patient previously treated with one of the following therapies? ***Please select answer below:***

❑Peginterferon / Ribavirin ❑Peginterferon / Ribavirin **AND** an *****NS3/4A protease inhibitor

❑Other treatment ***(please specify)***: _____

****NS3/4A Protease Inhibitors: boceprevir (Victrelis), glecaprevir, grazoprevir, paritaprevir, simeprevir (Olysio), telaprevir (Incivek), voxilaprevir***

14. Will Zepatier be used in combination with ribavirin? ❑Yes*** (****If YES, answer the following questions below)* ❑No

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 six 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 six months after the final dose? ❑Yes ❑No

15. **STANDARD Option Patient**: Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to Epclusa, Harvoni, Mavyret, Sovaldi or Vosevi? ***Please select answer below:***

❑**Yes** ***(specify medication(s) and result(s))***: _____

_____

❑**No**: Is there a clinical reason for not trying Epclusa, Harvoni, Mavyret, or Sovaldi? ❑Yes***** ❑No

If YES, please specify: _____

_____

PAGE 2

BlueCross BlueShield Federal Employee Program.

EPCLUSA PRIOR APPROVAL REQUEST

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.

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

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					

Epclusa (sofosbuvir & velpatasvir)

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

Please select strength and form:

❑150/37.5mg packet of pellets ❑200/50mg tablet ❑200/50mg packet of pellets ❑400/100mg tablet

****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 have a poor prognosis and treatment cannot be delayed or have a history where Hepatitis C infection is evident or suspected? ❑Yes***** ***(*If YES, please select one of the following below)*** ❑No
   ❑Poor prognosis and treatment cannot be delayed **OR** ❑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. What is the patient's genotype? ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑Not tested / Unspecified / Unknown
7. Has the patient had a kidney or liver transplant? ❑Kidney transplant ❑Liver transplant ❑No
8. Does the patient have decompensated cirrhosis? ❑Yes ❑No
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:***
   ❑NS5A inhibitor***** ❑Peginterferon / Ribavirin ❑Peginterferon / Ribavirin **AND** an ******NS3/4A protease inhibitor
   ❑sofosbuvir (Sovaldi) ❑Other treatment ***(please specify)***: _____
   ****NS5A inhibitors: daclatasvir (Daklinsa), elbasvir, ledipasvir, ombitasvir, pibrentasvir, velpatasvir***
   *****NS3/4A protease inhibitors: boceprevir (Victrelis), glecaprevir, grazoprevir, paritaprevir, simeprevir (Olysio), telaprevir (Incivek), voxilaprevir***
10. What is the patient's weight? _____ kg **OR** _____ lbs
11. Will Epclusa 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

BlueCross BlueShield Federal Employee Program

HARVONI PRIOR APPROVAL REQUEST

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.

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

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					

Harvoni (ledipasvir & sofosbuvir)

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

Please select strength: ❑**33.75/150mg** ❑**45/200mg** ❑**90/400mg**

****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. Is this a request for **INITIATION** or **CONTINUATION** of Harvoni? ***Please select answer below:***
   ❑**CONTINUATION** of therapy **(PA Renewal)**, please answer the questions on **PAGE 6**
   ❑**INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Does the patient have a diagnosis of hepatitis C? ❑Yes ❑No
4. Does the patient have a documented viral load (HCV RNA) from at least 6 months prior to this request for treatment? ❑Yes ❑No
5. 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 one of the following below)** ❑No
   ❑Poor prognosis and treatment cannot be delayed ❑Past history where Hepatitis C infection is evident or suspected
6. Does the patient currently have a viral load (HCV RNA) present in the serum? ❑Yes ❑No
7. 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
8. Has the patient had a kidney or liver transplant? ❑Kidney transplant ❑Liver transplant ❑No
9. What is the patient's genotype? ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑Not tested / Unspecified / Unknown
10. **If Genotype 1**: What was the pre-treatment HCV RNA? _____ million IU/mL ***(answer the following question below)***
    a. Will the HCV RNA be drawn at week 4? ❑Yes ❑No
11. Does the patient have a diagnosis of cirrhosis? ❑Yes***** ❑No
    ****If YES***, does the patient have a diagnosis of decompensated cirrhosis? ❑Yes ❑No
12. Is the patient treatment naïve? ❑Yes ❑No*****
    ****If NO***, was the patient previously treated with peginterferon and ribavirin with or without an NS3/4A protease inhibitor? ***Answer below:***
    ❑Peginterferon / Ribavirin ❑Peginterferon / Ribavirin **AND** an ****NS3/4A protease inhibitor
    ❑Other treatment ***(please specify)***: _____

****NS3/4A Protease Inhibitors: boceprevir (Victrelis), glecaprevir, grazoprevir, paritaprevir, simeprevir (Olysio), telaprevir (Incivek), voxilaprevir***

PLEASE PROCEED TO PAGE 5 FOR ADDITIONAL HARVONI INITIATION QUESTIONS

BlueCross BlueShield Federal Employee Program.

HARVONI
PRIOR APPROVAL REQUEST

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.

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

PAGE 5 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

13. **Age 3-17**: What is the patient's weight? _____ kg **OR** _____ lbs

14. Will the patient be using this medication 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 eligible? ❑Yes ❑No

BlueCross BlueShield Federal Employee Program

HARVONI
PRIOR APPROVAL REQUEST

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.

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

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					

CONTINUATION OF THERAPY (PA RENEWAL)

Harvoni

(ledipasvir & sofosbuvir)

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

Please select strength: ❑ **33.75/150mg** ❑ **45/200mg** ❑ **90/400mg**

****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. Is this a request for **INITIATION** or **CONTINUATION** of Harvoni? ***Please select answer below:***
   ❑ **INITIATION** of therapy, please answer the questions on **PAGES 4 and 5**
   ❑ **CONTINUATION** of therapy **(PA Renewal)**, please answer the questions below:

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

3. Does the patient have a diagnosis of hepatitis C? ❑Yes ❑No

4. Was the patient's **PREVIOUS** approval for a Harvoni 8 week approval for a genotype 1 treatment naïve patient without cirrhosis and with a **PRE**-treatment HCV-RNA of less than 6 million IU/mL? ***Please select answer below:***
   ❑**Yes**: Was the patient evaluated at week 4 to determine that the viral load would not be met within 8 weeks of treatment? ❑Yes ❑No
   ❑**No** ***(select one of the following)***: ❑Previous approval was for 12 to 24 weeks ❑Previous approval was for a different medication

5. Will the patient be using this medication in combination with ribavirin? ❑Yes ❑No

6. **Age 3-17**: What is the patient's weight? _____ kg **OR** _____ lbs

BlueCross BlueShield Federal Employee Program.

MAVYRET PRIOR APPROVAL REQUEST

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.

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

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					

Mavyret

(glecaprevir and pibrentasvir)

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

Please select strength and form: ❑**50mg/20mg packet of pellets** ❑**100mg/40mg tablet**

****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 one of the following below)** ❑No
   ❑Poor prognosis and treatment cannot be delayed **OR** ❑Past history where Hepatitis C infection is evident or suspected
4. **Age 3-17**: What is the patient's weight? _____ kg **OR** _____ lbs
5. Does the patient currently have a viral load (HCV RNA) present in the serum? ❑Yes ❑No
6. 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
7. Does the patient have decompensated cirrhosis? ❑Yes ❑No
8. Does the patient have moderate or severe hepatic impairment (Child-Pugh Class B or C)? ❑Yes ❑No
9. Has the patient had a kidney or liver transplant? ❑Kidney transplant ❑Liver transplant ❑No
10. What is the patient's genotype? ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑Unknown genotype
11. Is the patient treatment naïve? ❑Yes ❑No*****
    If NO, was the patient previously treated with any of the following therapies? ***Please select all that apply:***
    ❑NS5A inhibitor***** ❑NS3/4A protease inhibitor****** ❑Peginterferon / Ribavirin
    ❑Peginterferon / Ribavirin **WITH** sofosbuvir (Sovaldi)
    ❑Other treatment ***(please specify)***: _____
    NS5A Inhibitors: daclatasvir (Daklinsa), elbasvir, ledipasvir, ombitasvir, pibrentasvir, velpatasvir
    ****NS3/4A Protease Inhibitors: boceprevir (Victrelis), glecaprevir, grazoprevir, paritaprevir, simeprevir (Olysio), telaprevir (Incivek), voxilaprevir***
12. Does the patient have cirrhosis? ❑Yes ❑No
13. Does the patient have compensated cirrhosis? ❑Yes ❑No

BlueCross BlueShield Federal Employee Program.

SOVALDI
PRIOR APPROVAL REQUEST

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.

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Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

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 <u>all</u> 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 **<u>OR</u>** _____ 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

BlueCross BlueShield Federal Employee Program.

VOSEVI
PRIOR APPROVAL REQUEST

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.

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

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					

Vosevi

(sofosbuvir, velpatasvir, voxilaprevir)

****Check 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

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, select one of the following 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 a diagnosis of cirrhosis? ❑Yes***** ***(*If YES, please answer questions below)*** ❑No
   a. Does the patient have a diagnosis of **decompensated** cirrhosis? ❑Yes ❑No
   b. **If Genotype 3**: Does the patient have a diagnosis of **compensated** cirrhosis? ❑Yes ❑No
7. Has the patient had a kidney or liver transplant? ❑Kidney transplant ❑Liver transplant ❑No
8. **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***
9. What is the patient's genotype? ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑Unknown genotype
10. 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:
    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

BlueCross BlueShield Federal Employee Program.

VOSEVI
PRIOR APPROVAL REQUEST

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.

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

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.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Vosevi – FEP MD Fax Form Revised 5/31/2024