SOVALDI
Prior Authorization Form

Please note: Interferon products for hepatitis C also require prior authorization. Please complete appropriate form.

IF THIS IS AN URGENT REQUEST, please call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:
UPMC HEALTH PLAN PHARMACY SERVICES PHONE 1-800-979-UPMC (8762) FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY.
Incomplete responses may delay this request.

Office Contact:	**Provider Specialty:**	
Provider First Name:	**Provider Last Name:**	
Provider Phone:	**Provider Fax:**	**Provider NPI #:**

Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**	**Patient Age:**

Drug Requested:	**Strength:**	**Frequency:**	**Quantity:**

☐ **New Medication** ☐ **Ongoing Medication**	**If ongoing, please provide start date of:** **Interferon:** ______________________ **Sovaldi:** _________________________	**If medication is ongoing, did the member show improvement while on therapy?**	☐**Yes** ☐ **No**

Generic equivalent drugs will be substituted for brand-name drugs unless you specifically indicate otherwise.

Please indicate place of infusion: ☐ **Physician Office** ☐ **Hospital/Facility** ☐ **Patient Home**

Please provide facility/provider name and address:

Please indicate how drug will be billed:
- ☐ **Billed directly by the provider via JCODE.** **Provide JCODE:** ___________________________
- ☐ **Billed by a pharmacy and delivered to the provider.**
- ☐ **Billed by a pharmacy and delivered to the patient.**

Medical History

Does the member have a diagnosis of chronic hepatitis C? ☐Yes ☐No

If no, please indicate diagnosis: ____

Please indicate genotype: ____

*Please submit chart documentation of the laboratory test which confirmed the genotype.

Has the member been previously treated for chronic hepatitis C? ☐Yes ☐No

If yes, please indicate past treatment regimen(s): ________________________________

If yes, please indicate response to prior therapy:
- ☐ Relapser…………………........ Dates of therapy____
- ☐ Partial Responder……….…..... Dates of therapy____
- ☐ Null Responder……………. Dates of therapy____

Please provide chart documentation of baseline quantitative hepatitis C virus titer (HCV RNA) for the current course of therapy, including date and reference range of assay:

Date of baseline HCV RNA test:	HCV RNA result:

Does the member have cirrhosis? ☐Yes ☐No

If yes, please submit chart documentation of the ultrasound, CT scan, or MRI that confirmed the presence of cirrhosis.

Please be sure to complete and include the 2nd page of this form.

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Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:

Please be sure to complete and include this page with the 1st page of this form.

Does the member have decompensated cirrhosis? If yes, please indicate Child-Pugh Score and/or Class: ________________________	☐Yes ☐No
Does the member have advanced liver disease? If yes, please provide fibrosis score: ____ * Please submit chart documentation of a liver biopsy or fibrosis assessment from within the past three (3) years.	☐Yes ☐No

Does the member have any of the following illnesses or conditions? (Please check all that apply.)

- ☐ Autoimmune hepatitis or other conditions known to be exacerbated by interferon (if using as part of regimen)
- ☐ Female members who are pregnant
- ☐ Male members whose female partners are pregnant
- ☐ Known hypersensitivity to drugs used to treat hepatitis C
- ☐ Severe renal impairment or end-stage renal disease (please submit recent creatinine clearance level)
- ☐ Human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS)
- ☐ Hepatocellular carcinoma (please submit chart documentation describing current condition)

Will the member be taking Sovaldi in combination with other medication(s)? If yes, please indicate names: ____ ____	☐Yes ☐No

If the member is not using pegylated interferon as part of the treatment regimen, please indicate if any of the following apply and submit supporting chart documentation:

- ☐ Platelet count <90,000cells/mm3
- ☐ Absolute neutrophil count <1,500cells/mm3
- ☐ Serum creatinine >1.5 times upper limit of normal
- ☐ Hemoglobin <10g/dL
- ☐ Retinopathy
- ☐ CD4+ count <100cells/mm3 if co-infected with HIV
- ☐ Severe, uncontrolled psychiatric disease
  *Please submit chart documentation of an evaluation by a behavioral health specialist.
- ☐ Autoimmune disease
  Please specify: ___________________________
- ☐ History of pre-existing unstable cardiac disease
  Please specify: ___________________________
- ☐ Significant side effects to past treatment with interferon which required discontinuation
  Please specify: ___________________________
- ☐ Other. Please specify: ______________________
  ____
  ____

Has the member had a liver transplant in the past?	☐Yes ☐No
Is the member currently on the liver transplant waiting list?	☐Yes ☐No
Has the member been assessed for the ability to comply with the prescribed regimen and counseled on the potential risk of re-infection?	☐Yes ☐No
Does the member have a history of substance abuse? (Commercial, Medicaid, and CHIP only) If yes, please provide the following: ☐ Documentation that the member has not abused drugs in the past three (3) months ☐ Documentation of a recent (within three (3) months) urine drug screen, including testing for licit and illicit substances with the potential for abuse ☐ Documentation that the member has been screened for alcohol abuse	☐Yes ☐No

Please provide any additional information that should be considered in the space below: