Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Hepatitis C: Sovaldi

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: **Sovaldi** 2. Strength: _____ 3. Quantity per 30 Days: 28
4. Length of Therapy (in days): ☐ 365 days

Clinical Information

Total Length of Therapy (Check ONE):

☐ 12 weeks = Genotype 1, 2, or 4 for treatment-naïve and treatment-experienced adult beneficiaries without cirrhosis or with compensated cirrhosis (child-pugh A); or genotype 2 for treatment-naïve and treatment-experienced pediatric patients, 3 years of age or older, without cirrhosis or with compensated cirrhosis (child-pugh A). Genotype 1 and previously treated with a regimen containing an NS3/4A PI2 without prior treatment with an NS5A inhibitor.

☐ 24 weeks = Genotype 1 adult beneficiaries that are PEG-interferon ineligible; genotype 3 for treatment- naïve and treatment experienced adults without cirrhosis or with compensated cirrhosis (child-pugh A); or genotype 3 for treatment-naïve and treatment-experienced pediatric patients, 3 years of age or older, without cirrhosis or with compensated cirrhosis (child- pugh A)

☐ 48 weeks = Genotype 1,2,3, or 4 for adult beneficiaries with a diagnosis of Hepatocellular Carcinoma awaiting liver transplantation (up to 48 weeks or until liver transplantation, whichever comes first)

1. What is the member's Genotype? _____
2. Is the member 18 years of age or older with a diagnosis of Chronic Hepatitis C infection with confirmed genotype 1 or 4 without cirrhosis or with compensated cirrhosis? ☐ **Yes** ☐ **No**
3. Is the member 3 years of age or older with a diagnosis of Chronic Hepatitis C infection with confirmed genotype 2 or 3 without cirrhosis or with compensated cirrhosis? ☐ **Yes** ☐ **No**
4. Does the member have a CHC infection with hepatocellular carcinoma awaiting a liver transplant? ☐ **Yes** ☐ **No**
5. As the provider, are you reasonably certain that treatment will improve the member's overall health status? ☐ **Yes** ☐ **No**
6. Is Sovaldi being prescribed in combination with: ☐ Ribavirin and pegylated Interferon alfa for Genotype 1 or 4 ☐ Ribavirin for beneficiaries with genotype 1 who are peginterferon-ineligible (medical record documentation of previous peginterferon therapy or reason for ineligibility must be submitted for review) ☐ Ribavirin for Genotypes 2 or 3 and/or in CHC patients with hepatocellular carcinoma awaiting liver transplant
7. Is Sovaldi being used as monotherapy? ☐ **Yes** ☐ **No**
8. Is Sovaldi being used with any other sofosbuvir containing regimen? ☐ **Yes** ☐ **No**
9. Does the member have FDA labeled contraindication to sofosbuvir (Sovaldi)? ☐ **Yes** ☐ **No**
10. Is the member pregnant? ☐ **Yes** ☐ **No**
11. Does the member have severe renal impairment (CrCl less than 30mL/min), end stage renal disease, or requires dialysis (AASLD/IDSA 2014)? ☐ **Yes** ☐ **No**
12. Is the member a non-responder to sofosbuvir? ☐ **Yes** ☐ **No**
13. Has the member previously failed therapy with a treatment regimen that included sofosbuvir? ☐ **Yes** ☐ **No**
14. Does the member have hepatocellular carcinoma and is not awaiting liver transplant? ☐ **Yes** ☐ **No**

Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

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