

Hepatitis C: sofosbuvir-velpatasvir (generic for Epclusa)

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: **sofosbuvir-velpatasvir (generic for Epclusa)** 2. Strength: _____
3. Quantity per 30 Days: 28
4. Length of Therapy: 12 Weeks

Clinical Information

1. Is the member 3 years of age or older with a diagnosis of chronic hepatitis C (CHC) with genotype 1, 2, 3, 4, 5, or 6? Yes No **Genotype is:** _____
2. Are medical records documenting the diagnosis of chronic hepatitis C with genotype and subtype being submitted with this request? Yes No ****Lab test results MUST be attached to the PA to be approved.****
(documentation of genotype waived for treatment naïve beneficiaries).
3. Does the member have a documented quantitative HCV RNA at baseline that was tested within the past 6 months (medical documentation required)? Yes No - **HCN RNA (IU/ml):** _____ **and/or log10 value:** _____
4. As the provider, are you reasonably certain that treatment will improve the member's overall health status?
 Yes No
5. Does the member have FDA-labeled contraindications to sofosbuvir-velpatasvir? Yes No
6. Will sofosbuvir-velpatasvir be used in combination with other drugs containing sofosbuvir? Yes No

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.