NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Sofosbuvir-Velpatasvir (generic for Epclusa)

Beneficiary Information

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

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext._____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: __28__
11. Length of Therapy): ☐ 12 Weeks

Clinical Information

1. Is the beneficiary 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 if treatment naïve beneficiaries)**
3. Does the beneficiary have a documented quantitative HCV RNA at baseline that was tested within the past 6 months (medical documentation
   required)? ☐ **Yes** ☐ **No HCV RNA (IU/ml): _____ and/or log10 value: _____**
4. As the provider, are you reasonably certain that treatment will improve the beneficiary's overall health status?
   ☐ **Yes** ☐ **No**
5. Does the beneficiary 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.