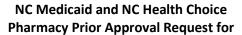


NC Medicaid and NC Health Choice Pharmacy Prior Approval Request for **Sovaldi**

Beneficiary Information				
1. Beneficiary Last Name: 2. First Name: 3. Beneficiary ID #: 4. Beneficiary Date of Birth:		t Name:		
3. Beneficiary ID #:	4. Beneficiary Date of Bi	rth:	5. Beneficiary Gender:	
Prescriber Information				
6. Prescribing Provider NPI #:				
7. Requester Contact Information - Nar				
Drug Information				
8. Drug Name:	9. Strength:	10	. Quantity Per 30 Days:	
11. Length of Therapy (in days): 12 W	eeks 🗆 24 Weeks 🗀 48 Wee	eks		
Clinical Information				
\square 24 weeks = Genotype 1 adult bene	A); or genotype 2 for treatments of soils or with compensated cirrowith a regimen containing an efficiaries that are PEG-interferences or with compensated cirrowatients, 3 years of age or older or adult beneficiaries with a diagraph of the compensated cirrowatients. The compensated cirrowaties of chronic hepatitis C infections or with compensated cirrowate diagnosis of chronic hepatitics or with compensated cirrowate diagnosis of chronic hepatitics are with compensated cirrowate diagnosis of chronic hepatitics. The compensated cirrowate diagnosis of chronic hepatitics are with compensated cirrowate diagnosis of chronic hepatitics. The compensated cirrowate diagnosis of chronic hepatitics are with results must be attached to the compensation with ribavirin and pegylomation with ribavirin for benefit revious peginterferon therapy mation with ribavirin for genotics. The compensation with ribavirin for genotics.	ent-naïve and treatmen rhosis (child-pugh A). NS3/4A Pl ₂ without prion ineligible; genotype osis (child-pugh A); Or ger, without cirrhosis or values of the following of the following with one of the following with one of the following with one of the following liver transplant its C with genotype and the PA to be approved. It baseline that was tested and/or log10 value: prove the beneficiary's lated interferon alfa for ficiaries with genotype 1 by or reason for ineligibility pes 2 and 3 and/or in the PA to De PA to D	or treatment with an NS5A inhibitor 3 for treatment-naïve and treatment genotype 3 for treatment-naïve and with compensated cirrhosis (childar Carcinoma awaiting liver lowing confirmed diagnosis': years of age or older years of age or older subtype being submitted with this ** ed within the past 6 months (medical coverall health status? T genotypes 1 and 4? □ Yes □ No 1 who are peginterferon-ineligible lity must be submitted for review)? CHC beneficiaries with hepatocellular	

Pharmacy PA Call Center: (866) 246-8505





12. Does the beneficiary have severe renal impairment (CrCl less (AASLD/IDSA 2014)? \square Yes \square No	s than 30 mL/min), end stage renal disease, or require dialysis			
13. Is the beneficiary a non-responder to sofosbuvir? ☐ Yes ☐ No 14. Has the beneficiary previously failed therapy with a treatment regimen that included sofosbuvir? ☐ Yes ☐ No				
				15. Does the beneficiary have hepatocellular carcinoma and is not awaiting a liver transplant? \Box Yes \Box No
Signature of Prescriber:	Date:			
(Prescriber Signature Ma	ndatory)			
I certify that the information provided is accurate and complete	e to the best of my knowledge, and I understand that any			
falsification, omission, or concealment of material fact may sub				

Fax this form to CSRA at (855) 710-1969 DHB Pharmacy 32

Pharmacy PA Call Center: (866) 246-8505 10.01.2021