OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Sovaldi® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
❑ Chronic hepatitis C (CHC)
❑ Other diagnosis: ____________________________________ ICD-10 Code(s): ________________________________

Clinical Information:

Document the patient's HCV genotype:* _______________

Will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has a diagnosis of chronic hepatitis C genotype 1, 2, 3, or 4?* ❑ **Yes** ❑ **No**
**Please note: Chart documentation of the above is required to be submitted along with this fax.*

Select if Sovaldi is prescribed by or in consultation with one of the following specialists:
❑ Gastroenterologist ❑ HIV specialist certified through the American Academy of HIV Medicine
❑ Hepatologist ❑ Infectious disease specialist

Is this request for continuation of prior Sovaldi (sofosbuvir) therapy? ❑ **Yes** ❑ **No**

Select if the patient has had trial and failure, contraindication, or intolerance to the following, as appropriate for the patient's genotype:
❑ Harvoni (ledipasvir/sofosbuvir) ❑ Epclusa (sofosbuvir/velpatasvir) ❑ Mavyret (glecaprevir/pibrentasvir)

Select if the patient will be using Sovaldi in combination with the following medication(s):
❑ Peginterferon alfa and ribavirin
❑ Ribavirin
❑ Olysio (simeprevir)
Has the patient experienced failure with a previous treatment regimen that includes Olysio or other HCV NS3/4A protease inhibitors [e.g., Incivek (telaprevir), Victrelis (boceprevir)]? ❑ **Yes** ❑ **No**
❑ Daklinza (daclatasvir)
Has the patient failed prior HCV NS5A-containing regimen (e.g., Daklinza)? ❑ **Yes** ❑ **No**

Does the patient have cirrhosis? ❑ **Yes** ❑ **No**

Does the patient have decompensated liver disease (e.g., Child –Pugh Class B or C)? ❑ **Yes** ❑ **No**

Is the patient a liver transplant recipient? ❑ **Yes** ❑ **No**

Has the patient experienced failure with a previous treatment regimen that includes Sovaldi? ❑ **Yes** ❑ **No**

Is this request for continuation of prior Sovaldi plus Daklinza therapy? ❑ **Yes** ❑ **No**

Document the patient's weight: __________ lbs/kg

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Sovaldi® Prior Authorization Request Form (Page 2 of 2)

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Quantity Limit Requests:

What is the quantity requested per DAY? ________

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: ____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

____

____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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