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Visit [go.covermymeds.com/OptumRx](http://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

## Vosevi® Prior Authorization Request Form

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:
<input type="checkbox"/> Check if requesting <b>brand</b>	Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>		

### Clinical Information (required)

**Select the diagnosis below:**

Chronic hepatitis C virus (HBV)

Other diagnosis: \_\_\_\_\_ ICD-10 Code(s): \_\_\_\_\_

**Clinical Information:**

Document the patient's hepatitis C virus (HCV) genotype:\* \_\_\_\_\_

Will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has a diagnosis of HCV genotype 1, 2, 3, 4, 5, or 6?\*  Yes  No

*\*Please note: Chart documentation of the above is required to be submitted along with this fax.*

Is the patient a previous relapser to an NS5A-based regimen (e.g., Daklinza [daclatasvir]; Epclusa [sofosbuvir/velpatasvir]; Harvoni [ledipasvir/sofosbuvir]; Mavyret [glecaprevir/pibrentasvir]; Technivie [ombitasvir/paritaprevir/ritonavir]; Viekira [ombitasvir/paritaprevir/ritonavir & dasabuvir]; Zepatier [elbasvir/grazoprevir])?  Yes  No

Is the patient a previous relapser to a sofosbuvir-based regimen without an NS5A inhibitor?  Yes  No

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

Select if Vosevi 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

Will the patient be receiving Vosevi in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]?  Yes  No

**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.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Vosevi\_Comm\_2018Dec-W