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 virus (HCV)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Document the patient's HCV genotype: _____

Select if Sovaldi will be used in combination with the following:

❑ Daklinza (daclatasvir) ❑ Peginterferon alfa and ribavirin ❑ Ribavirin

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

Does the patient have decompensated liver disease (defined as Child-Pugh Class B or C)? ❑ **Yes** ❑ **No**

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

Select if the patient has had trial and failure, contraindication, or intolerance to the following, if applicable for the patient's genotype:

❑ Epclusa, sofosbuvir/velpatasvir) ❑ Harvoni, ledipasvir/sofosbuvir ❑ Mavyret (glecaprevir/pibrentasvir)

❑ Vosevi (sofosbuvir/velpatasvir/voxilaprevir) ❑ Zepatier (elbasvir/grazoprevir)

For use with ribavirin, also answer the following:

Document the patient's weight: _____ (lbs/kg)

For use with Daklinza therapy, also answer the following:

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

Has the patient failed a prior HCV NS5A-containing regimen (e.g., Daklinza)? ❑ **Yes** ❑ **No**

If "yes" to the above question, is there documentation the patient does not have NS5A inhibitor resistance-associated variants detected using commercially available assays? ❑ **Yes** ❑ **No**

Quantity Limit:

What is the quantity requested per MONTH? _____

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

❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____

❑ Other: _____

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

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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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.