

North Carolina Department of Health and Human Services  
**Division of Medical Assistance**  
**Sovaldi Prior Authorization Form**

**Recipient Information**

1. Recipient Name: \_\_\_\_\_ 2. Recipient ID #: \_\_\_\_\_

**FOR GENOTYPE 3 - DAKLINZA® PRIOR AUTHORIZATION FORM MUST ALSO BE FILLED OUT**

**Drug Information**

3. **Sovaldi** 4. **28** Per **28** Days

5. Length of Therapy (Check ONE)<sup>1</sup>:

\_\_\_ **8 weeks of 12** = Genotype 1 or 4

\_\_\_ **8 weeks of 12** = Genotype 2

\_\_\_ **8 weeks of 12** = Genotype 3

Sovaldi® + peg interferon alfa + ribavirin

Sovaldi® + ribavirin

Sovaldi® + Daklinza®<sup>2</sup>

**Liver Transplant Eligible**

\_\_\_ **Up to 48 weeks or until liver transplantation whichever comes first** = Genotype 1, 2, 3 or 4 with diagnosis of hepatocellular carcinoma meeting Milan Criteria (awaiting liver transplantation)

**Full documentation must accompany request**

**(Approve for full 48 weeks if documentation shows hepatocellular carcinoma meeting Milan Criteria)**

Sovaldi® + ribavirin

<sup>1</sup>**Approval will be for 8 weeks unless otherwise noted above. A new PA is required with new HCV-RNA lab values to continue therapy**

<sup>2</sup>**For Genotype 3, the Daklinza Prior Authorization Form must also be filled out and sent in**

**Clinical Information**

1. The patient readiness to treat form is filled out and signed by the patient: YES or NO (circle one)\*

2. The Child-Pugh Grade is: \_\_\_\_\_ (see Hepatitis-C Clinical Criteria)

3. The Genotype is: \_\_\_\_\_\*

4. HCV-RNA (IU/ML) \_\_\_\_\_ and/or log10 value \_\_\_\_\_ (must be within last 6 months)\*

5. Fibrosis stage \_\_\_\_\_ (see Hepatitis-C Clinical Criteria)\*

6. For **Genotype 1**: Patient has tried and failed Viekira Pak: YES or NO (Circle One)

6a. IF NO, give clinical reason as to why Sovaldi must be used first: \_\_\_\_\_

\* Readiness to treat form and **actual lab test** results (**NOT PROGRESS NOTES**) **MUST** be attached to the PA to be approved.

This form can be uploaded into the secure NCTracks Provider Portal, faxed, or mailed to CSC. If faxed, the Standard Drug Request Form **MUST** be the first page faxed. Fax all forms and lab work to CSC at: (855) 710-1969.  
Pharmacy PA Call Center: (866) 246-8505

