NC Medicaid
Pharmacy Prior Approval Request for

Vosevi

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: 28
11. Length of Therapy (in days): ☐ 365 Days

Clinical Information

1. What is the beneficiary's Genotype? _____
2. What is the beneficiary's Child Pugh? _____
3. Is the beneficiary 18 years of age or older with a diagnosis of chronic Hepatitis C (CHC) infection with confirmed genotype 1,2,3,4,5, or genotype 6 without cirrhosis or with compensated cirrhosis?
   ☐ Yes ☐ No
4. Has the beneficiary previously been treated with an HCV regimen containing an NS5A inhibitor and have a genotype of 1, 2, 3, 4, 5, or 6; or has the beneficiary previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor and has a genotype of 1a or genotype 3? ☐ Yes ☐ No
5. As the provider, are you reasonably certain that treatment will improve the beneficiary's overall health status? ☐ Yes ☐ No
6. Does the beneficiary have FDA labeled contraindications to Vosevi? ☐ Yes ☐ No

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

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

Pharmacy PA Call Center: (866) 246-8505

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