STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
PO BOX 2943 HARTFORD, CT 06104
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110 OR (860) 269-2035

Connecticut Medical Assistance Program Hepatitis C Prior Authorization (PA) Request Form- Sovaldi™ (Sofosbuvir)

[This and other pharmacy PA forms are available at www.ctdssmap.com]

To Be Completed By Prescriber

Prescriber Information	Patient Information
Prescriber's NPI:	Client Medicaid ID Number:
Prescriber Name:	Patient Name:
Phone # ( )	Patient DOB: / /
Fax # ( )	

Important message for Providers

- The prescriber can be any physician who holds a current unrestricted license to practice medicine AND who is enrolled in the Connecticut Medical Assistance Program. If the prescriber is NOT a board certified gastroenterologist, hepatologist, infectious disease specialist or HIV specialist, a one-time written consultation from one of these will be required within the past 3 months. This consulting specialist must have recommended Sovaldi™ therapy prior to approval. **Documentation of the written consultation must be retained in the patient's medical record and be available upon request.**
- A full course of Sovaldi™ usually consists of 12 weeks of therapy. The prescriber will submit additional information to justify a request for more than 12 weeks of therapy.
- Sovaldi™ will be **dispensed for 2 weeks at a time** with further refills being available every 2 weeks for a total of 12 weeks (or longer if indicated, with approved request).
- Non-compliance with the regimen or patient's failure to obtain refills every 2 weeks will result in discontinuation of previous prior approval, and no further therapy with Sovaldi™ will be approved.
- The prescriber agrees to obtain all FDA recommended tests and to monitor therapy with Sovaldi™ for the entire duration of therapy.
- **Prescriber must maintain a copy of a signed patient commitment letter for Sovaldi™ treatment, which includes the appropriate information listed above.**

Criteria for Medical Necessity Review

Patient is 18 years of age or older.	□ Yes □ No
Patient has a diagnosis of Chronic Hepatitis C infection of any genotype 1 – 6 confirmed by HCV ribonucleic acid (RNA) level, and a metavir score of 3 or 4 or equivalent, including FIB-4 >3.25, liver imaging which demonstrates evidence for liver cirrhosis, or non-invasive serum markers or transient elastography which corresponds to F3 or F4.	□ Yes □ No
Patients has a fibrosis score less than F3, but has documented HIV or other co-morbid conditions that warrant more timely Hepatitis C treatment.	□ Yes □ No □ Not applicable
Patient has documented Genotype 3 infection requiring extended 24 week course of therapy with Sovaldi™ .	□ Yes □ No

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Female patients must not be currently pregnant which must be documented with a negative pregnancy test obtained within the previous 30 days, and monthly thereafter during treatment with Sovaldi™. **Documentation of the negative pregnancy tests must be retained in the patient's medical record and be available upon request.**	□ Yes □ No □ Not applicable
Male patients must not have a female partner who is currently pregnant, and must agree to use adequate birth control to avoid pregnancy during treatment.	□ Yes □ No □ Not applicable
Patient does not have end stage renal disease requiring dialysis.	□ Yes □ No
Patient does not have glomerular filtration rate < 30mL/minute/1.73m_2.	□ Yes □ No
If Genotype 1, documentation is maintained demonstrating why the patient is not considered "interferon-ineligible."	□ Yes □ No □ Not applicable
Patient must not have evidence or known diagnosis of any malignancy diagnosed within the last 12 months, or be currently receiving or planning to receive chemotherapy or radiation therapy. Exceptions will be made for hepatocellular carcinoma patients upon request.	□ Yes □ No
Patient is not enrolled in Hospice.	□ Yes □ No
Patient is not taking rifampin, anticonvulsants, St. John's Wort or other prescribed or over-the-counter products known to be harmful while taking Sovaldi™.	□ Yes □ No
Patient must undergo treatment with Sovaldi™ for an FDA approved indication and is prescribed with FDA-approved combination therapy. Further, no contraindications for use of Sovaldi™ exist as specified in the product labeling.	□ Yes □ No
Patient has no history of a full or incomplete course of Sovaldi treatment.	□ Yes □ No

I certify that use of Sovaldi™ for this patient is consistent with the above criteria/guidelines.

Prescriber Signature: _____Date:_____

(By his/her signature, the prescriber confirms the criteria/guideline information above is accurate and verifiable in patient records.)

Please complete the information below **only** if the prescriber who signed above is <u>not</u> a gastroenterologist, hepatologist, infectious disease specialist or HIV specialist.

Board Certified Specialist Name:_____
(please indicate specialty)

☐ Gastroenterologist ☐ Hepatologist ☐ Infectious disease specialist ☐ HIV specialist

Phone Number:_____