Prescriber Criteria Form

Vosevi 2025 PA Fax 2177-A v1 010125.docx
Vosevi (sofosbuvir/velpatasvir/voxilaprevir)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Vosevi (sofosbuvir/velpatasvir/voxilaprevir).

Drug Name:
Vosevi (sofosbuvir/velpatasvir/voxilaprevir)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.

1	Does the patient have a diagnosis of hepatitis C virus (HCV) infection? [If no, then then no further questions.]	Yes	No
2	Prior to initiating therapy, has hepatitis C virus (HCV) infection been confirmed by the presence of hepatitis C virus ribonucleic acid (HCV RNA) in serum? [If no, then no further questions.]	Yes	No
3	Is the requested drug being prescribed for use alone (i.e., without any other antiviral for hepatitis C)? [If no, then skip to question 21.]	Yes	No
4	Is the request for a patient with recurrent hepatitis C virus (HCV) infection post liver transplantation or a patient who is a kidney transplant recipient? [If no, then skip to question 7.]	Yes	No
5	Does the patient have genotype 1, 2, 3, 4, 5 or 6? [If no, then no further questions.]	Yes	No
6	Is the request for a patient who failed prior treatment with any direct-acting antiviral regimen? [If yes, then skip to question 33.] [If no, then no further questions.]	Yes	No

7	Is the request for a patient who failed prior treatment with glecaprevir/pibrentasvir (Mavyret)? [If no, then skip to question 10.]	Yes	No
8	Does the patient have genotype 1a, 1b, 2, 3, 4, 5 or 6? [If no, then no further questions.]	Yes	No
9	Does the patient have cirrhosis? [If yes, then no further questions.] [If no, then skip to question 33.]	Yes	No
10	Does the patient have genotype 1a, 1b, or 2 infection? [If no, then skip to question 13.]	Yes	No
11	Is the request for a patient who failed prior treatment with a nonstructural protein 5A (NS5A) inhibitor-containing regimen other than glecaprevir/pibrentasvir (Mavyret)? [If yes, then skip to question 33.]	Yes	No
12	Is the request for a patient who failed prior treatment with a sofosbuvir (Sovaldi)-containing regimen? [If yes, then skip to question 33.] [If no, then no further questions.]	Yes	No
13	Does the patient have genotype 4, 5 or 6 infection? [If no, then skip to question 15.]	Yes	No
14	Is the request for a patient who failed prior treatment with a direct-acting antiviral (DAA) regimen other than glecaprevir/pibrentasvir (Mavyret)? [If yes, then skip to question 33.] [If no, then no further questions.]	Yes	No
15	Does the patient have genotype 3 infection? [If no, then no further questions.]	Yes	No
16	Does the patient meet both of the following: A) the request is for a patient who failed prior treatment with a direct-acting antiviral (DAA) regimen, including glecaprevir/pibrentasvir (Mavyret) B) the patient does not have cirrhosis? [If yes, then skip to question 33.]	Yes	No
17	Is the request for a treatment-naive patient? [If no, then no further questions.]	Yes	No
18	Does the patient have compensated cirrhosis (Child Turcotte Pugh class A)? [If no, then no further questions.]	Yes	No
19	Has laboratory testing for the presence of nonstructural protein 5A (NS5A) inhibitor resistance-associated substitutions been performed? [If no, then no further questions.]	Yes	No

20	Was the Y93H substitution associated with velpatasvir resistance detected? [If yes, then skip to question 33.] [If no, then no further questions.]	Yes	No
21	Is the requested drug being requested for use in combination with ribavirin? [If no, then no further questions.]	Yes	No
22	Is the request for a patient with recurrent hepatitis C virus (HCV) infection post liver transplantation or a patient who is a kidney transplant recipient? [If no, then skip to question 25.]	Yes	No
23	Does the patient have genotype 1, 2, 3, 4, 5 or 6? [If no, then no further questions.]	Yes	No
24	Is the request for a patient who failed prior treatment with any direct-acting antiviral regimen? [If yes, then skip to question 33.] [If no, then no further questions.]	Yes	No
25	Is the request for a patient who failed prior treatment with glecaprevir/pibrentasvir (Mavyret)? [If no, then skip to question 28.]	Yes	No
26	Does the patient have genotype 1, 2, 3, 4, 5 or 6? [If no, then no further questions.]	Yes	No
27	Does the patient have compensated cirrhosis? [If yes, then skip to question 33.] [If no, then no further questions.]	Yes	No
28	Is the request for a patient who failed prior treatment with sofosbuvir/velpatasvir/voxilaprevir (Vosevi)? [If no, then skip to question 30.]	Yes	No
29	Does the patient have genotype 1, 2, 3, 4, 5 or 6? [If yes, then skip to question 35.] [If no, then no further questions.]	Yes	No
30	Does the patient have genotype 3 infection? [If no, then no further questions.]	Yes	No
31	Is the request for a patient who failed prior treatment with any direct-acting antiviral regimen? [If no, then no further questions.]	Yes	No
32	Does the patient have compensated cirrhosis (Child Turcotte Pugh class A)? [If no, then no further questions.]	Yes	No
33	Does the patient have decompensated cirrhosis or moderate or severe hepatic impairment (Child Turcotte Pugh [CTP] class B or C)? Note: The requested drug is not indicated in patients with moderate or severe hepatic	Yes	No

	impairment (Child Turcotte Pugh [CTP] class B or C). [If yes, then no further questions.]		
34	Has the patient received greater than or equal to 12 weeks of treatment with the requested drug? [No further questions.]	Yes	No
35	Does the patient have decompensated cirrhosis or moderate or severe hepatic impairment (Child Turcotte Pugh [CTP] class B or C)? Note: The requested drug is not indicated in patients with moderate or severe hepatic impairment (Child Turcotte Pugh [CTP] class B or C). [If yes, then no further questions.]	Yes	No
36	Has the patient received greater than or equal to 24 weeks of treatment with the requested drug?	Yes	No

Comments:	____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: ________________________________ Date:____________________