Prescriber Criteria Form Epclusa 2024 PA Fax 1508-A v2 010124.docx Epclusa (sofosbuvir and velpatasvir), Sofosbuvir And Velpatasvir 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 Epclusa.

Drug Name (select from list of drugs shown):

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 yes, then skip to question 3.]	Yes	No
2	Is the request for a patient who has received a liver or non-liver organ transplant from a hepatitis C virus (HCV)-viremic donor and the requested drug is being requested for use alone (i.e., without any other antiviral for hepatitis C)? [If yes, then skip to question 29.] [If no, then no further questions.]	Yes	No
3	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
4	Is the requested drug being prescribed for use alone (i.e., without any other antiviral for hepatitis C)? [If no, then skip to question 17.]	Yes	No
5	Does the patient have decompensated cirrhosis (Child Turcotte Pugh class B or C)? [If yes, then skip to question 15.]	Yes	No
6	Is the request for a patient with recurrent hepatitis C virus infection post liver transplantation and genotype 1, 2, 3, 4, 5, or 6 infection? [If yes, then skip to question 29.]	Yes	No

7	Is the request for a patient who has received a kidney transplant with genotype 1, 2, 3, 4, 5, or 6 infection and is either of the following: A) treatment-naïve, B) has not failed prior treatment with a direct-acting antiviral? [If yes, then skip to question 29.]	Yes	No
8	Does the patient have genotype 1, 2, 3, 4, 5, or 6 infection? [If no, then skip to question 12.]	Yes	No
9	Is the request for a treatment-naive patient or a patient who failed prior treatment with peginterferon alfa and ribavirin with or without a hepatitis C virus protease inhibitor (boceprevir [Victrelis], simeprevir [Olysio] or telaprevir [Incivek])? [If yes, then skip to question 29.]	Yes	No
10	Has the patient experienced prior treatment with either of the following: A) interferon-based regimen with or without ribavirin, B) sofosbuvir (Sovaldi)-based regimen (e.g., sofosbuvir and ribavirin with or without interferon, sofosbuvir and ledipasvir, sofosbuvir and velpatasvir)? [If no, then no further questions.]	Yes	No
11	Does the patient meet all of the following: A) pediatric patient, B) has not received a nonstructural protein 3/4A (NS3/4A) protease inhibitor (for example, simeprevir [Olysio], telaprevir [Incivek], boceprevir [Victrelis], sofosbuvir, velpatasvir, and voxilaprevir [Vosevi], elbasvir and grazoprevir [Zepatier]) or a nonstructural protein 5A (NS5A) inhibitor (for example, daclatasvir [Daklinza], ledipasvir and sofosbuvir [Harvoni])? [If yes, then skip to question 29.] [If no, then no further questions.]	Yes	No
12	Is the request for a treatment-naïve patient without cirrhosis? [If no, then no further questions.]	Yes	No
13	Does the patient have all of the following: A) human immunodeficiency virus (HIV) positive, B) currently taking a tenofovir disoproxil fumarate (TDF)-containing regimen, C) an eGFR less than 60 milliliters per minute (mL/min)? [If yes, then no further questions.]	Yes	No
14	Does the patient have any of the following: A) hepatitis B surface antigen (HBsAg) positive, B) currently pregnant, C) known or suspected hepatocellular carcinoma, D) prior liver transplantation? [If yes, then no further questions.] [If no, then skip to question 29.]	Yes	No
15	Does the patient have genotype 1, 2, 3, 4, 5, or 6 infection? [If no, then no further questions.]	Yes	No
16	Does the patient have a reason to avoid ribavirin? [If yes, then skip to question 30.] [If no, then no further questions.]	Yes	No
17	Is the requested drug being prescribed for use in combination with ribavirin? [If no, then no further questions.]	Yes	No

18	Does the patient have decompensated cirrhosis (Child Turcotte Pugh class B or C)? [If no, then skip to question 20.]	Yes	No
19	Is the request for a patient with recurrent hepatitis C virus infection post liver transplantation? [If yes, then skip to question 27.] [If no, then skip to question 25.]	Yes	No
20	Does the patient have genotype 3 infection? [If no, then no further questions.]	Yes	No
21	Is the request for a treatment-naive patient? [If no, then no further questions.]	Yes	No
22	Does the patient have compensated cirrhosis (Child Turcotte Pugh class A)? [If no, then no further questions.]	Yes	No
23	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
24	Was the Y93H substitution associated with velpatasvir resistance detected? [If yes, then skip to question 29.] [If no, then no further questions.]	Yes	No
25	Does the patient have genotype 1, 2, 3, 4, 5, or 6 infection? [If no, then no further questions.]	Yes	No
26	Is the request for a patient who failed prior treatment with a sofosbuvir (Sovaldi)- or nonstructural protein 5A (NS5A) inhibitor-based regimen (for example, daclatasvir [Daklinza], ledipasvir and sofosbuvir [Harvoni])? [If yes, then skip to question 30.] [If no, then skip to question 29.]	Yes	No
27	Does the patient have genotype 1, 2, 3, 4, 5 or 6 infection? [If no, then no further question.]	Yes	No
28	Is the request for a treatment-naïve patient? [If no, then skip to question 30.]	Yes	No
29	Has the patient received greater than or equal to 12 weeks of treatment with the requested drug? [No further questions.]	Yes	No
30	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:_____