Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Hepatitis C: Vosevi

Member Information

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

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: **Vosevi** 2. Strength: _____ 3. Quantity per 30 Days: 28
4. Length of Therapy (in days): ☐ 365 Days

Clinical Information

1. What is the member's Genotype? _____
2. What is the member's Child Pugh? _____
3. Is the member 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 member 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 member 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 member's overall health status? ☐ Yes ☐ No
6. Does the member 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.