COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Hepatitis C-33 Medicare

Phone: 833-674-6200 (option 3) Fax back to: 877-503-7231

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Please note that Elixir will process the request as written, including drug name, with no substitution.

Drug Name and Strength:

Directions / SIG:

☐ **REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the standard review timeframes (72 hours for initial requests or 7 days for appeals) may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.**

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:

☐ Chronic hepatitis C virus (HCV) infection ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Please provide the patient's HCV genotype, subtype and quantitative HCV RNA (viral load) testing any time prior to therapy along with documentation of these lab results:

Q6. Is the patient post-transplant? (If yes, please specify):

Sunray Specialty Pharmacy

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Q7. Please provide the patient's cirrhosis status:

Q8. Please provide the patient's prior treatment history (if any) and response to prior treatment:

Q9. What is the planned duration of therapy with the requested medication?

Q10. Is the requested medication being prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist?

☐ Yes ☐ No

Q11. For GENOTYPES 1, 4, 5, or 6, has the patient tried and failed, has a contraindication or intolerance to Harvoni, Epclusa, or Mavyret prior to request of Vosevi?

☐ Yes
☐ No
☐ N/A - Patient is not genotype 1, 4, 5, 6 or is not requesting Vosevi

Q12. For GENOTYPES 2 or 3, has the patient tried and failed, has a contraindication or intolerance to Epclusa or Mavyret prior to request for Vosevi?

☐ Yes
☐ No
☐ N/A - Patient is not genotype 2 or 3 or is not requesting Vosevi

Q13. If the patient has NOT tried any of the above medications, is there a reason why these medications cannot be used (i.e. contraindication, history of adverse event, etc)?

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Prescriber Signature Date