



Hepatitis C Treatments - Vosevi
Prior Authorization Form

Fax completed form to:
855-207-0250
For questions regarding this
prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that members receiving a prescription for hepatitis C treatments to meet specific clinical criteria for coverage which can be found at <https://ndmedicaid.acentra.com/ndpdl/>. **No need for chart notes or labs** (HCV RNA level, fibrosis, drug/alcohol screens).

Member Name	Member Date of Birth	Weight (kg)	Member Medicaid ID Number	
Prescriber Name	Telephone Number		Fax Number	
Address	City		State	Zip Code
Prescriber NPI	Diagnosis for the Request		Genotype (if known)	
Requested Drug and Directions:	Duration:	Strength:	Dosage Form (e.g., tablet):	
The following questions are used to verify the prescribed regimen is appropriate: 1. The member has experienced Direct Acting Antiviral failure or incomplete therapy after receiving greater than or equal to 28 days of therapy? ☐ YES ☐ NO 2. The member has Chronic Hepatitis C as evidenced by the submission of the date and value of 1 positive HCV RNA test since the most recent DAA treatment (HCV RNA level must be within the last 24 months). Date and value of detectable lab _____ Date of most recent DAA treatment _____				
Non-Preferred Agents: 1. Clinical justification must be provided explaining why the member is unable to use the preferred product (subject to clinical review).				
Prescriber (or Staff) / Pharmacy Signature**			Date	
** : By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.				