



Vosevi

Express Scripts  
Prior Authorization  
Phone 1-844-424-8886  
Fax 1-877-251-5896

To start your Part D Coverage Determination request, you (or your representative or your doctor or other prescriber) should contact Express Scripts, Inc (ESI):

- You may Call ESI at 1-844-424-8886, 24 hours a day, 7 days a week, TTY users: 1-800-716-3231
- You may Fax your request to: 1-877-251-5896 (Attention: Medicare Reviews)
- You may also send your request via email to: [medicarepartdparequests@express-scripts.com](mailto:medicarepartdparequests@express-scripts.com)

|                     |                      |
|---------------------|----------------------|
| Member's Last Name: | Member's First Name: |
| SCAN ID number:     | Date of Birth:       |
| Prescriber's Name:  | Contact Person:      |
| Office phone:       | Office Fax:          |

|             |            |
|-------------|------------|
| Medication: | Diagnosis: |
|-------------|------------|

**SECTION A** Please answer the following questions

1. What is the diagnosis or indication?
  - ⊖ Chronic Hepatitis C, Genotype 1
  - ⊖ Chronic Hepatitis C, Genotype 1a
  - ⊖ Chronic Hepatitis C, Genotype 2
  - ⊖ Chronic Hepatitis C, Genotype 3
  - ⊖ Chronic Hepatitis C, Genotype 4
  - ⊖ Chronic Hepatitis C, Genotype 5
  - ⊖ Chronic Hepatitis C, Genotype 6
  - ⊖ Other (*Please specify*):

---



---



---



---

Continue to page 2.

- 2.  Yes  No Has the patient previously been treated with an HCV regimen containing an NS5A inhibitor (e.g., Harvoni, Epclusa, ledipasivr-sofosbuvir, sofosbuvir-velpatasvir, etc.)?
- 3.  Yes  No Has the patient previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor?
- 4.  Yes  No Will Vosevi be used concurrently with rifampin, amiodarone, P-gp inducers, or moderate to potent CYP2B6, CYP2C8, or CYP3A4 inducers (e.g., carbamazepine)?
- 5.  Yes  No Is Vosevi being written or recommended by an Infectious Disease Specialist, Gastroenterologist, or Hepatologist?

***Please document the symptoms and/or any other information important to this review:***

---



---



---



---



---

**SECTION B**    Physician Signature

\_\_\_\_\_

PHYSICIAN SIGNATURE

\_\_\_\_\_

DATE

**FAX COMPLETED FORM TO: 1-877-251-5896**

Our response time for prescription drug coverage standard requests is 72 hours. If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received. View our formulary and Prior Authorization criteria online at <http://www.scanhealthplan.com>