

**FLORIDA MEDICAID  
MANAGED CARE PLAN KICK PAYMENT REQUEST FORM  
SOVALDI® (SOFOSBUVIR)  
(WEEK OF THERAPY: 24 – 48 WEEK)**



**Note: Form must be completed in full. An incomplete form may be returned. MUST ALSO SUBMIT INFORMATION ON THE SOVALDI/OLYSIO KICK PAYMENT SPREADSHEET.**

Recipient's Medicaid ID#	Date of Birth (MM/DD/YYYY)
<input type="text"/>	<input type="text"/>
Recipient's Full Name	
<input type="text"/>	
Prescriber's Full Name	
<input type="text"/>	
Prescriber License # (ME, OS, ARNP, PA)	
<input type="text"/>	
Prescriber Phone Number	Prescriber Fax Number
<input type="text"/>	<input type="text"/>

- SOVALDI (sofosbuvir) 400 mg tab
  - Initiation of therapy
  - Continuation of therapy

1. Does recipient have a diagnosis of hepatocellular carcinoma (155.0 – malignant neoplasm of liver, primary 155.1 – malignant neoplasm of intrahepatic bile ducts 230.8 – Carcinoma in situ of liver and biliary system)?  
Yes                      No
  
2. Is the recipient being managed in a liver transplant center?  
Yes                      No
  
3. Please check all that apply:
  - Initial review criteria has been met (may be subject to review).
  - Recipient is currently on Sovaldi therapy (claim history will be validated).
  - Approaching 24 week HCV RNA viral load performed and provided with Kick Payment Form submission.
  - Recipient is on concurrent Ribavirin therapy for a 48 week duration or until time of liver transplantation, whichever occurs first.
  - Sovaldi prescribed by hepatologist, gastroenterologist, or infectious disease specialist.

**Managed Care Plan Contact information (please print):**

Name: \_\_\_\_\_  
Phone number: \_\_\_\_\_  
E-mail address: \_\_\_\_\_

Date form completed: \_\_\_\_\_

**REQUIRED FOR REVIEW:** All copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs. All documentation from prescribing physician submitted to the managed care plan.

Fax Information to:



Pharmacy Provider Services  
Fax: 855-825-2717  
Phone: 1-800-617-5727