MC-Rx
Powered by ProCare Rx

Mavyret®

Ticket #: _____ **Request Date:** _____ **Request Time:** _____

Mavyret™ Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Chronic hepatitis C virus (HCV)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Document the patient's hepatitis C virus (HCV) genotype:* _____

Will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has a diagnosis of HCV genotype 1, 2, 3, 4, 5, or 6?* ❑ **Yes** ❑ **No**

**Please note: Chart documentation of the above is required to be submitted along with this fax.*

Select if Mavyret is prescribed by or in consultation with one of the following specialists:

- ❑ Gastroenterologist
- ❑ Hepatologist
- ❑ HIV specialist certified through the American Academy of HIV Medicine
- ❑ Infectious Disease Specialist

Select the patient's treatment experience below:

- ❑ The patient is treatment-naïve
- ❑ The patient has experienced treatment failure with a previous treatment regimen that included interferon, peginterferon, ribavirin, and/or Sovaldi (sofosbuvir)
- ❑ The patient has experienced treatment failure with a previous treatment regimen that included a HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)]
- ❑ The patient has experienced previous treatment failure with a treatment regimen that included an NS5A inhibitor [e.g., Daklinza (daclatasvir)]

Does the patient have cirrhosis? ❑ **Yes** ❑ **No**

Does the patient have decompensated liver disease (e.g., Child-Pugh Class B or C)? ❑ **Yes** ❑ **No**

Will the patient be receiving Mavyret in combination with another HCV direct activing antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]? ❑ **Yes** ❑ **No**

Select if the patient has had a history of intolerance or contraindication to the following therapies:

❑ Epclusa ❑ Harvoni ❑ Zepatier

Is this request for continuation of prior Mavyret therapy? ❑ **Yes** ❑ **No**

Please note that this form is to be completed by the prescribing physician. This document and others, if attached, contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Mavyret™ Prior Authorization Request Form (Page 2 of 2)

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Quantity Limit Requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other:

_____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Authorized Medical Signature:	
Telephone:	**Date:**

When Completed Return To:

MC-Rx Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

Please note: This request may be denied unless all required information is received.

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