Mavyret Continuation PA Form

Recipient Information

1. Recipient Last Name:_____ 2. First Name:_____

3. Recipient ID #:_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Prescriber Information

6. Prescribing Provider NPI#:_____

7. Requester Contact Information - Name:_____ Phone #:_____ Ext:_____

Drug Information

8. **Mavyret** 9. **84** Per 28 Days

10. How many additional weeks of therapy are requested for the beneficiary? _____
11. Is the beneficiary treatment-experienced? ☐ Yes ☐ No
12. Does the beneficiary have cirrhosis? ☐ Yes ☐ No
13. What is the genotype? _____
14. Please list the previous treatment regimen. _____
15. Have HCV RNA labs been collected four (4) or more weeks after the initial prescription fill date? (Medical documentation with results required) ☐ Yes ☐ No
16. Do the results of the HCV RNA labs indicate a response to therapy (>/= 2 log reduction in HCV RNA or HCV RNA < 25IU/ml)? ☐ Yes ☐ No

At week 4 of the treatment cycle

HCV RNA (IU/ml): _____

And/or log 10 value _____

Before treatment documented on original Prior Authorization request

HCV RNA (IU/ml): _____

And/or log 10 value: _____

17. Has the beneficiary exhibited any sign of high risk behavior (ex. recurring alcoholism, IV drug use, etc.)? ☐ Yes ☐ No
18. Has the beneficiary failed to complete HCV disease evaluation appointments or procedures? ☐ Yes ☐ No
19. During the initial course of therapy, was the beneficiary compliant with the prescribed medication regimen? ☐ Yes ☐ No
20. Has the beneficiary's medication fill history been reviewed for compliance? ☐ Yes ☐ No

Signature of Prescriber:_____ Date: _____

(Prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (877) 386-4695

Pharmacy PA Call Center: (833) 585-4309