

## Pharmacy Prior Approval Request for Mavyret

### Beneficiary Information

1. Beneficiary Last Name: \_\_\_\_\_ 2. First Name: \_\_\_\_\_  
 3. Beneficiary ID #: \_\_\_\_\_ 4. Beneficiary Date of Birth: \_\_\_\_\_ 5. Beneficiary Gender: \_\_\_\_\_

### Prescriber Information

6. Prescribing Provider NPI #: \_\_\_\_\_  
 7. Requester Contact Information - Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_

### Drug Information

8. Drug Name: \_\_\_\_\_ 9. Strength: \_\_\_\_\_ 10. Quantity Per 30 Days: 84  
 11. Length of Therapy (in days):  8 Weeks  12 Weeks  16 Weeks

### Clinical Information

Total Length of Therapy (Check ONE):

- 8 weeks** = All genotypes: without cirrhosis or with compensated cirrhosis (Child Pugh-A)
  - 12 weeks** = Treatment naïve patients with a Liver or Kidney transplant recipients, or treatment-experienced patients with HCV Genotype 1 and previously treated with a regimen containing an NS3/4A PI<sub>2</sub> without prior treatment with an NS5A inhibitor
  - 16 weeks** = Recipients with an HCV Genotype 1 and previous treated with a regimen containing an NS5A inhibitor without prior treatment with an NS3/4A protease inhibitor or a recipient with an HCV Genotype 3 and previously treated with a regimen containing PRS<sub>3</sub>
1. Is the beneficiary 12 years of age or older or weighing at least 45kg with a diagnosis of chronic hepatitis C (CHC) with Confirmed genotype 1,2,3,4,5, or 6?  Yes  No **Genotype is:** \_\_\_\_\_ (documentation of genotype waived if treatment naïve patient)
  2. Does the beneficiary have cirrhosis?  Yes  No **Child-Pugh is:** \_\_\_\_\_
  3. Are medical records documenting the diagnosis of chronic hepatitis C with genotype and subtype being submitted with this request?  Yes  No **\*\*Lab test results MUST be attached to the PA to be approved.\*\*** (documentation of genotype waived if treatment naïve patient)
  4. Does the beneficiary have a documented quantitative HCV RNA at baseline that was tested within the past 6 months (medical documentation required)?  Yes  No **HCV RNA (IU/ml):** \_\_\_\_\_ and/or **log<sub>10</sub> value:** \_\_\_\_\_
  5. As the provider, are you reasonably certain that treatment will improve the beneficiary's overall health status?  
 Yes  No
  6. Does the Beneficiary have an FDA labeled contraindications to Mavyret?  Yes  No
  7. Is Mavyret being used in combination with atazanavir and rifampin?  Yes  No
  8. Does the Beneficiary have moderate to severe hepatic impairment (Child-Pugh B or C)?  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: (866)-399-0929

Pharmacy PA Call Center: (833) 585-4309