

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

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

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)
<p>Select the diagnosis below:</p> <p><input type="checkbox"/> Chronic hepatitis C virus (HCV)</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
<p>Clinical Information:</p> <p>Document the patient's hepatitis C virus (HCV) genotype:* _____</p> <p>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?* <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>*Please note: Chart documentation of the above is required to be submitted along with this fax.</i></p> <p>Select if Mavyret is prescribed by or in consultation with one of the following specialists:</p> <p><input type="checkbox"/> Gastroenterologist <input type="checkbox"/> HIV specialist certified through the American Academy of HIV Medicine</p> <p><input type="checkbox"/> Hepatologist <input type="checkbox"/> Infectious Disease Specialist</p> <p>Select the patient's treatment experience below:</p> <p><input type="checkbox"/> The patient is treatment-naïve</p> <p><input type="checkbox"/> The patient has experienced treatment failure with a previous treatment regimen that included interferon, peginterferon, ribavirin, and/or Sovaldi (sofosbuvir)</p> <p><input type="checkbox"/> 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)]</p> <p><input type="checkbox"/> The patient has experienced previous treatment failure with a treatment regimen that included an NS5A inhibitor [e.g., Daklinza (daclatasvir)]</p> <p>Does the patient have cirrhosis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have decompensated liver disease (e.g., Child-Pugh Class B or C)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will the patient be receiving Mavyret in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Select if the patient has had a history of intolerance or contraindication to the following therapies:</p> <p><input type="checkbox"/> Eplclusa <input type="checkbox"/> Harvoni <input type="checkbox"/> Zepatier</p> <p>Is this request for continuation of prior Mavyret therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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.

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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:

ProCare PBM 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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