WellCare
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NC Medicaid

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

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. _____ Per 28 Days

10. Length of Therapy (Check ONE):

___ **4 more weeks** = All genotypes: with compensated cirrhosis (Child-Pugh A)

Clinical Information

1. HCV-RNA (IU/ml) _____ and/or log10 value _____ (Baseline values before Mavyret)
2. HCV-RNA (IU/ml) _____ and/or log10 value _____ at week 4 or later of Mavyret treatment cycle (must show less than 25IU/ml or 2log10 reduction in HCV-RNA to continue.)*

* **HCV-RNA lab test results MUST be attached to the PA to be approved.**

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: **(800) 678-3189** Pharmacy PA Call Center: **(866) 799-5318**