NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

WellCare
Beyond Healthcare. A Better You.

Mavyret Prior Authorization Form / Initial Request 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. Drug Name: **Mavyret** 9. **__84__**Per 28 Days

10. **Total Length of Therapy** (Check One):
*Only 8 weeks can be approved with this form. Must use continuation form to request last 4 weeks

___ **8 weeks** = All genotypes: without cirrhosis
___ **12 weeks** = All genotypes: with compensated cirrhosis (Child-Pugh A)

Clinical Information

1. Is the beneficiary 18 years old or older with a diagnosis of chronic hepatitis C (CHC) with confirmed genotype 1,2,3,4,5, or 6? ____**Yes**____**No** **Genotype is:** _____ Fibrosis **stage is:** _____

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**

4. Which of the following are included with the submitted medical records to document the staging of liver disease:

___ Metavir scores ___ FibroSURE score ___ IASL scores
___ Batts-Ludwig scores ___ Fibroscan score ___ Ishak scores
___ APRI score ___ Radiological imaging consistent with cirrhosis
___ Physical findings or clinical evidence consistent with cirrhosis as attested by the prescribing physician

5. 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 **log10 value** _____

6. A commitment to abstinence from alcohol and IV drug use is required. For beneficiaries with a recent history of alcohol abuse or IV drug use (within the past year), enrollment in a treatment program and/or counseling, and/or an active support group is also required. Beneficiaries must agree to toxicology and/or alcohol screens as needed. Does the beneficiary have a history of alcohol abuse or IV drug use? _____**Yes** _____**No**

7. As the provider, are you reasonably certain that treatment will improve the beneficiary's overall health status? _____**Yes** _____**No**

8. Has the Beneficiary Readiness Evaluation been completed with the beneficiary meeting ALL of the Beneficiary Readiness Criteria? Evaluation form must be submitted. _____**Yes** _____**No**

Readiness to treat form and 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**