PRO ACT
PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

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

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:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Chronic hepatitis C virus (HCV)

❑ Other diagnosis:_____ICD-10 Code(s): _____

Clinical Information:

Document the patient's hepatitis C virus (HCV) genotype:* _____

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?* ❑ **Yes** ❑ **No**

**Please note: Chart documentation of the above is required to be submitted along with this fax.*

Select if Mavyret is prescribed by or in consultation with one of the following specialists:

❑ Gastroenterologist
❑ Hepatologist
❑ HIV specialist certified through the American Academy of HIV Medicine
❑ Infectious Disease Specialist

Select the patient's treatment experience below:

❑ The patient is treatment-naïve
❑ The patient has experienced treatment failure with a previous treatment regimen that included interferon, peginterferon, ribavirin, and/or Sovaldi (sofosbuvir)
❑ 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)]
❑ The patient has experienced previous treatment failure with a treatment regimen that included an NS5A inhibitor [e.g., Daklinza (daclatasvir)]

Does the patient have cirrhosis? ❑ **Yes** ❑ **No**

Does the patient have decompensated liver disease (e.g., Child-Pugh Class B or C)? ❑ **Yes** ❑ **No**

Will the patient be receiving Mavyret in combination with another HCV direct activing antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]? ❑ **Yes** ❑ **No**

Select if the patient has had a history of intolerance or contraindication to the following therapies:

❑ Epclusa ❑ Harvoni ❑ Zepatier

Is this request for continuation of prior Mavyret therapy? ❑ **Yes** ❑ **No**

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

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?

_____

_____

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	