

Initial Prior Authorization Request

REQUEST DATE: / /

PATIENT INFORMATION

PATIENT INFORMATION

PATIENT'S MEDICAID ID NUMBER

[illegible]

PATIENT'S DATE OF BIRTH

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PATIENT'S FULL NAME

[illegible]

PRESCRIBER INFORMATION

PRESCRIBER'S FULL NAME

[illegible]

PRESCRIBER PHONE NUMBER:

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PRESCRIBER FAX NUMBER:

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PRESCRIBER SPECIALTY:

PRESCRIBER NPI #:

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Summary of FDA Approved Prescribing Information

The recommended dosage of MAVYRET is 3 tablets taken orally once daily with food. MAVYRET is contraindicated on patients with severe hepatic impairment. Coadministration with atazanavir and rifampin is also contraindicated. Please refer to FDA approved product information for prescribing details and approved indications.

INFORMATION REQUIRED FOR PRIOR AUTHORIZATION APPROVAL

- | | | | |
|--|--|---|-----------------------------|
| 1. Is the patient 18 years of age or older? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Patient supervised by: | | <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Infectious disease specialist <input type="checkbox"/> A physician specialized in hepatitis treatment and management
<input type="checkbox"/> A physician/mid-level practitioner working in consultation with gastroenterologist or infectious disease specialist | |
| 3. Patient has a diagnosis of (please attach a letter of medical necessity with documentation): | | <input type="checkbox"/> Chronic Hepatitis C (CHC) mono-infection
<input type="checkbox"/> Other: _____ | |
| 4. Patient pretreatment HCV RNA level: _____ | | Date: _____ | |
| 5. Patient has compensated liver disease? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | | If yes, Provide Liver Fibrosis Assessment: _____ | |
| 6. Patient has identified HCV genotype: | | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 |
| | | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 |
| | | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 |
| 7. Is the patient treatment naïve? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Is MAVYRET to be used in combination with any other Hepatitis C medications? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | | If yes, please explain: _____ | |
| 9. Does the patient have a history of adherence problem to any prior therapy? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| a. If yes, please briefly describe the nature of the problem (attach additional sheet if necessary). | | _____ | |
| b. Please describe any educational efforts undertaken to improve patient's adherence (attach additional sheet if necessary). | | _____ | |
| c. Has the patient been counseled on barriers to HCV therapy, such as alcohol, and illicit drug use? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Is the patient on any one of the following medications: P-gp inducers, (e.g., rifampin or St. John's wort), carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifampin, atazanavir, rifabutin, rifapentine, tipranavir/ritonavir, cyclosporine, rosuvastatin, simeprevir or efavirenz containing regimens? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Has the patient been previously treated with any HCV therapy which included both an NS5A inhibitor and a NS3/4A protease inhibitor? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Has the patient tested negative for Hepatitis B (HBV)? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. If MAVYRET is intended for use in pregnant women, has the patient been informed about the risks/benefits? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. The beneficiary has agreed to participate in the Hepatitis C monitoring program provided by the District's Pharmacy Benefit Manager; clearly understands that only one course of therapy is allowed in his/her District Medicaid lifetime; and, unless there is legitimate documented evidence, a request for loss/stolen medication replacement will not be authorized? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

I certify that, to the best of my knowledge, all information I have provided on this request is complete and factual.

PRESCRIBER'S SIGNATURE: _____ **DATE:** _____