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CardinalCare
Virginia's Medicaid Program

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

HEPATITIS C ANTIVIRALS: NON-PREFERRED

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

Mavyret®, Mavyret® pellet pack, and sofosbuvir/velpatasvir are **preferred – no PA required**.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

Prescriber Specialty: Non-preferred hepatitis C medication must be prescribed by one of the following specialty physicians below or be in consultation with one of the following:

☐ Gastroenterologist ☐ Hepatologist ☐ Transplant specialist ☐ Infectious disease

☐ Other: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS (You may check more than one box.)

☐ Acute or chronic hepatitis C ☐ Compensated cirrhosis ☐ Hepatocellular carcinoma

☐ Decompensated cirrhosis (Child-Pugh score class B or C) ☐ Status post-liver transplant

☐ Severe renal impairment (eGFR < 30 mL/min/1.73m^2) or end stage renal disease requiring hemodialysis

HCV Genotype:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

Choose One: ☐ Treatment initiation ☐ Continuation of therapy, current week: _____

PREVIOUS HEPATITIS C TREATMENTS

☐ **Treatment naïve**

☐ **Treatment experienced** (please list treatment): _____

Document dates received: _____

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:

Prime Therapeutics Management LLC

Attn: GV – 4201

P.O. Box 64811

St. Paul, MN 55164-0811