UnitedHealthcare Community Plan

NC Pharmacy Prior Approval Request for

Mavyret

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____ Provider Fax #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____ _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: __84__
11. Length of Therapy (in days): ☐ 8 Weeks ☐ 12 Weeks ☐ 16 Weeks

Clinical Information

Total Length of Therapy (Check ONE):

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

☐ **12 weeks =** Treatment naïve patients with a Liver or Kidney transplant recipients, or treatment-experienced patients with HCV Genotype 1 and previously treated with a regimen containing an NS3/4A PI_2 without prior treatment with an NS5A inhibitor

☐ **16 weeks** = Recipients with an HCV Genotype 1 and previous treated with a regimen containing an NS5A inhibitor without prior treatment with an NS3/4A protease inhibitor or a recipient with an HCV Genotype 3 and previously treated with a regiment containing PRS_3

1. Is the beneficiary 12 years of age or older or weighing at least 45kg with a diagnosis of chronic hepatitis C (CHC) with genotype 1,2,3,4,5, or 6? ☐ **Yes** ☐ **No** **Genotype is:** _____ (documentation of genotype waived if treatment naïve patient)
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** ****Lab test results MUST be attached to the PA to be approved.**** (documentation of genotype waived if treatment naïve patient
4. 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:** _____
5. As the provider, are you reasonably certain that treatment will improve the beneficiary's overall health status? ☐ **Yes** ☐**No**
6. Does the Beneficiary have an FDA labeled contraindications to Mavyret? ☐ **Yes** ☐**No**
7. Is Mavyret being used in combination with atazanavir and rifampin? ☐ **Yes** ☐**No**
8. Does the Beneficiary have moderate to severe hepatic impairment (Child-Pugh B or C)? ☐ **Yes** ☐**No**

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 1-866-940-7328 Pharmacy PA Call Center: 1-855-258-1593

10.01.2021