WellCare
Beyond Healthcare. A Better You.

NC Medicaid and NC Health Choice 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 #: _____
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 (including liver or kidney transplant recipients) or a recipient with an HCV

Genotype 3 and previously treated with a regimen containing PRS_3 (including liver or kidney transplant recipients).

1. Is the beneficiary 3 years of age or older 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 **1-800-678-3189**
Pharmacy PA Call Center: **1-866-799-5318**

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