Prior Authorization Form
Mavyret®

Access this PA form at: https://optumrx.com/oe_tenncare/prescriber

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per member.

Member Information (required)			Prescriber Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	DEA#:	
Date of Birth:			Specialty:		
Street Address:			Office Phone:	Office Fax:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
			Is the prescriber a TennCare provider with a Medicaid ID? ❑ **Yes** ❑ **No** Is the prescriber a single-patient contract holder for this patient? ❑ **Yes** ❑ **No**		

For additional details, please refer to the clinical criteria available at https://optumrx.com/oe_tenncare/prescriber

Clinical Criteria Documentation *****Do **not** include documentation that is not requested on this form*****		
Requested product: ☐ Mavyret® tablet ☐ Mavyret® pellets		
1. Is the request for a pediatric patient less than 20 kg? If yes, what is the requested strength? _____	☐ Yes	☐ No
2. What is the diagnosis and duration of therapy for which this drug is being requested? ☐ Chronic Hepatitis C, genotype 1 ☐ Chronic Hepatitis C, genotype 2 ☐ Chronic Hepatitis C, genotype 3 ☐ Chronic Hepatitis C, genotype 4 ☐ Chronic Hepatitis C, genotype 5 ☐ Chronic Hepatitis C, genotype 6 ☐ Other _____ Requested Duration of Therapy: _____		
3. Does the patient have a diagnosis of compensated cirrhosis?	☐ Yes	☐ No
4. Does the patient have any of the following: (if yes to any, go to question 4, if no, go to question 5)		
a. decompensated cirrhosis, defined as a Child-Pugh score of greater than 6 (Class B or C)?	☐ Yes	☐ No
b. history of HIV?	☐ Yes	☐ No
c. co-infection with Hepatitis B Virus	☐ Yes	☐ No
d. prior history with direct acting hepatitis C antiviral?	☐ Yes	☐ No

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5. If "yes" to any question 3a-d, please indicate the specialty of the prescribing physician: ☐ Gastroenterologist ☐ Hepatologist ☐ Infectious Disease Specialist ☐ *Other If "Other," has prescriber consulted with a physician specialist with experience in the treatment of Hepatitis C infection (e.g., infectious disease, gastroenterologist, or hepatologist)? Name of Prescriber Consulted: _____ Date of Consult: _____		
6. Is the patient positive for Hepatitis B via confirmatory test?	☐ Yes	☐ No
7. Which of the following best describes the patient prior to this course of treatment for Hepatitis C? ☐ Treatment Naïve ☐ Treatment experienced		
8. If treatment experienced, provide attached documentation for ALL of the following: ☐ Quantitative HCV RNA level measured 12 weeks after completion of previous treatment ☐ Previous treatment history ☐ Genotype testing		
Please note any other information pertinent to this PA request: _____ _____ _____		

_____ _____

Prescriber Signature (required) Date

(By signature, the Physician confirms the above information is accurate and verifiable by patient records.)

Fax this form to: 1-866-434-5523
Phone: 1-866-434-5524
OptumRx will provide a response within 24 hours upon receipt.

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