

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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
			Is the prescriber a single-patient contract holder for this patient? <input type="checkbox"/> Yes <input type="checkbox"/> 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 Mavyret® Product			
Preferred	Non-Preferred		
<input type="checkbox"/> Mavyret® tablet	<input type="checkbox"/> Mavyret® pellets		
Is the request for a pediatric patient less than 20 kg? If yes, what is the requested strength? _____		<input type="checkbox"/> Yes	<input type="checkbox"/> No
1. What is the diagnosis and duration of therapy for which this drug is being requested? <input type="checkbox"/> Chronic Hepatitis C, genotype 1 <input type="checkbox"/> Chronic Hepatitis C, genotype 2 <input type="checkbox"/> Chronic Hepatitis C, genotype 3 <input type="checkbox"/> Chronic Hepatitis C, genotype 4 <input type="checkbox"/> Chronic Hepatitis C, genotype 5 <input type="checkbox"/> Chronic Hepatitis C, genotype 6 <input type="checkbox"/> Other _____ Requested Duration of Therapy: _____			
2. Does the patient have a diagnosis of compensated cirrhosis?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. 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)? b. history of HIV? c. co-infection with Hepatitis B Virus d. prior history with direct acting hepatitis C antiviral?		<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

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<p>4. Please check the box corresponding to the specialty of the prescribing physician:</p> <p><input type="checkbox"/> Gastroenterologist</p> <p><input type="checkbox"/> Hepatologist</p> <p><input type="checkbox"/> Infectious Disease Specialist</p> <p><input type="checkbox"/> *Other</p> <p>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)?</p> <p>Name of Prescriber Consulted: _____ Date of Consult: _____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>5. Is the patient positive for Hepatitis B via confirmatory test?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>6. If requesting a non-preferred agent (Mavyret® pellets), please submit documentation of allergy to inactive ingredient in preferred product that is not in the requested product and any other information pertinent to this prior authorization request.</p> <p>_____</p> <p>_____</p> <p>_____</p>		
<p>7. Which of the following best describes the patient prior to this course of treatment for Hepatitis C?</p> <p><input type="checkbox"/> Treatment Naïve <input type="checkbox"/> Treatment experienced</p>		
<p>8. If treatment experienced, provide attached documentation for ALL of the following:</p> <p><input type="checkbox"/> Quantitative HCV RNA level measured 12 weeks after completion of previous treatment</p> <p><input type="checkbox"/> Previous treatment history</p> <p><input type="checkbox"/> Genotype testing</p>		
<p>Please note any other information pertinent to this PA request: _____</p> <p>_____</p> <p>_____</p>		

Prescriber Signature (required)

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

Date

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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