PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Medicare Part D - Mavyret

Phone: 1-800-728-7947 Fax back to: 866-880-4532

SCOTT AND WHITE manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State, Zip:	City, State, Zip:	
Member Phone:		

Drug Name:	☐ Expedited/Urgent
Directions:	

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:
Q1. Please provide ICD code(s) for diagnosis
Q2. Please provide patient Hepatitis C virus genotype.
Q3. What is the requested duration of therapy?
Q4. Specify the prescriber's specialty. ☐ Hepatologist ☐ Board Certified Infectious Disease specialist ☐ Board Certified Gastroenterologist ☐ Other (please specify)
Q5. What is the patient's baseline HCV RNA viral load?
Q6. Select the agents that the patient has been treated with previously: ☐ Treatment naive ☐ Peginterferon (PEG) and Ribavirin (RBV) - Dual Therapy ☐ Incivek or Victrelis-based regimen ☐ Daklinza, Epclusa, Harvoni, Mavyret, Olysio, Sovaldi, Technivie, Viekira, Vosevi, or Zepatier-based regimen ☐ Other - please specify
Q7. Describe the patient's previous treatment history and include dates of treatment, length of treatment, outcome/response.

Q8. Select the status that applies to this patient and provide documentation to support selection.

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- ☐ Clinically DECOMPENSATED cirrhosis
- ☐ Compensated cirrhosis
- ☐ No evidence of cirrhosis

Q9. Has the patient had a liver transplant?

☐ Yes ☐ No

Q10. Additional Comments:

Physician Signature **Date**