REALRx

PRIOR AUTHORIZATION REQUEST FORM

HEPATITIS C DIRECT ACTING ANTIVIRALS

ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, Mavyret®

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ ledipasvir/sofosbuvir (Harvoni® authorized generic), ☐ sofosbuvir/velpatasvir (Epclusa® authorized generic), ☐ Mavyret® (glecaprevir/pibrentasvir)

Non-Formulary: ☐ Sovaldi® (sofosbuvir), ☐ Viekira Pak® (ombitasvir/paritaprevir/ritonavir and dasabuvir), ☐ Vosevi® (sofosbuvir/velpatasvir/voxilaprevir), ☐ Zepatier® (elbasvir/grazoprevir)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
For use in Hepatitis C Virus (HCV) infection			
1. Is this request for an expedited review? 2. By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
3. Is the requesting prescriber a gastroenterologist, hepatologist, transplant specialist, infectious disease specialist, or a provider registered with Project ECHO-HCV (Extension for Community Healthcare Outcomes)?	☐	☐	
4. Does the member have a documented diagnosis of chronic HCV infection with documentation of a positive qualitative HCV RNA test?	☐	☐	**Please provide documentation**
5. Does documentation include a quantitative viral load?	☐	☐	**Please provide documentation**
6. Has the member's HCV genotype been obtained? • Not required for Sofosbuvir/velpatasvir (Epclusa® authorized generic)	☐	☐	**Please provide documentation**
7. Does the member have current issues with compliance?	☐	☐	

8. If the member has a psychiatric condition, is the member currently stable and adequately managed?	☐	☐	**Please provide documentation**
9. If the request is for Mavyret, does the member have moderate or severe impairment (Child-Pugh class B or C)?	☐	☐	**Please provide documentation**
For use in retreatment of Hepatitis C Virus (HCV) infection			
1. Is the requesting prescriber a gastroenterologist, hepatologist, transplant specialist, infectious disease specialist, or a provider registered with Project ECHO-HCV (Extension for Community Healthcare Outcomes)?	☐	☐	
2. Does the member have a documented diagnosis of chronic HCV infection with documentation of a positive qualitative HCV RNA test?	☐	☐	**Please provide documentation**
3. Does documentation include a quantitative viral load?	☐	☐	**Please provide documentation**
4. If the member had a sofosbuvir-based treatment failures, is the request for the preferred agent Mavyret?	☐	☐	**Please provide documentation**
5. If the member had a Mavyret treatment failure, is the request for Vosevi?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

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Policy: PHARM- 030
Origination Date: 07/01/2016
Reviewed/Revised Date: 01/17/2024
Next Review Date: 01/17/2025
Current Effective Date: 02/01/2024