

## PRIOR AUTHORIZATION REQUEST FORM

### Hepatitis C Direct-Acting Antivirals

Epclusa, Harvoni, Mavyret, sofosbuvir/ledipasvir, sofosbuvir/velpatasvir, Sovaldi, Vosevi, Zepatier

**For authorization, please answer each question and fax this form PLUS chart notes back to RealRx Medicaid Prior Authorization Department 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 Pharmacy Customer Service for assistance.

- Healthy U: 855-856-5694
- Healthy U CHIP: 855-203-3633
- Health Choice Utah: 855-864-1404

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:

**Preferred Products:** Mavyret (glecaprevir/pibrentasvir), sofosbuvir/velpatasvir

**Non-preferred Products:** Epclusa (sofosbuvir/velpatasvir), Harvoni (ledipasvir/sofosbuvir), sofosbuvir/ledipasvir\*, Sovaldi (sofosbuvir), Vosevi (sofosbuvir/velpatasvir/voxilaprevir), Zepatier (elbasvir/grazoprevir)

\*Brand required is Harvoni

Product Requested: \_\_\_\_\_

Directions for Use: \_\_\_\_\_

Criteria for Approval (ALL of the following criteria must be met):	Yes	No
1. Does the patient have a diagnosis of chronic or acute hepatitis C infection confirmed by lab documentation and quantitative baseline HCV-RNA?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Check the diagnosis below:</b>		
<input type="checkbox"/> Acute Hepatitis C (Mavyret Only)		
<input type="checkbox"/> Chronic hepatitis C		
** Yes to the above, proceed to Part 1		
** No to the above, use the Medication Coverage Exception Prior Authorization Form		

**Part 1: (All questions below must be answered with documentation and chart notes provided as appropriate)**

1. Has the patient been previously treated for HCV?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the patient previously had a liver or kidney transplant?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the patient have decompensated cirrhosis (Child Pugh class B or C)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Is the patient co-infected with HIV or Hepatitis B?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the patient have known or suspected hepatocellular carcinoma?	<input type="checkbox"/>	<input type="checkbox"/>
6. Is the patient pregnant? (current guidelines do not recommend treatment)	<input type="checkbox"/>	<input type="checkbox"/>
7. Will the patient receive treatment with an agent other than sofosbuvir/velpatasvir or Mavyret? ** Yes to ANY of the above, answer question 8 and proceed to Part 2 ** No to ALL of the above, proceed to Part 3	<input type="checkbox"/>	<input type="checkbox"/>
8. Is the medication being prescribed by or in consultation with one of the following specialist(s)?	<input type="checkbox"/>	<input type="checkbox"/>

<input type="checkbox"/> Infectious Disease Specialist <input type="checkbox"/> Hepatologist <input type="checkbox"/> Gastroenterologist		
<b>Part 2</b>		
9. Has the patient been previously treated for HCV?  Previous Treatment and Length: _____	<input type="checkbox"/>	<input type="checkbox"/>
10. Has the patient had an interruption in treatment due to medication nonadherence?  Please specify non-adherence issues: _____	<input type="checkbox"/>	<input type="checkbox"/>
11. If yes, has the previous issue(s) related to medication nonadherence been resolved and has the patient been counseled on the importance of adherence to HCV treatment?	<input type="checkbox"/>	<input type="checkbox"/>
12. Which HCV genotype is being treated? (submit laboratory confirmation of the HCV genotype) <input type="checkbox"/> 1a <input type="checkbox"/> 1b <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6		
13. What is the patient's HCV RNA level?  RNA Level: _____		
14. What is the requested duration of therapy? <input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> 12 weeks with ribavirin <input type="checkbox"/> 16 weeks <input type="checkbox"/> 24 weeks <input type="checkbox"/> 24 weeks with ribavirin <input type="checkbox"/> Other weeks requested: _____		
15. Has the prescriber demonstrated medical necessity for a non-preferred product?  Details: _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Part 3</b>		
16. What is the requested duration of therapy? <input type="checkbox"/> 8 weeks with Mavyret <input type="checkbox"/> 12 weeks with generic sofosbuvir/velpatasvir	<input type="checkbox"/>	<input type="checkbox"/>
<b>PRESCRIBER CERTIFICATION</b>		
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.		
Physician's Signature:	Date:	

**Initial Authorization:** Up to six (6) months

**Note:**

- Patient should be evaluated and/or counseled on clinically significant drug to drug interactions

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

Policy: PHARM-HYB-030  
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