SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Mavyret™ (Glecaprevir/Pibrentasvir) Initiation Prior Authorization Form

Member Name: _____ ***Date of Birth:***_____ ***Member ID#:***_____
Pharmacy NPI:_____ ***Pharmacy Phone:*** _____ ***Pharmacy Fax:***_____
Pharmacy Name:_____ ***Pharmacist Name:***_____
Prescriber NPI: _____ ***Prescriber Name:*** _____ ***Specialty:*** _____
Prescriber Phone:_____ ***Prescriber Fax:*** _____ ***Drug Name:*** _____
NDC:_____ ***Start Date:***_____

Clinical Information

1. HCV Genotype (including subtype if applicable): _____ Date Determined: _____
2. METAVIR Equivalent Fibrosis Stage:_____ Testing Type:_____
   Date Fibrosis Stage Determined:_____
3. Pre-treatment viral load in the last 12 months: _____ Date Taken: _____
   For METAVIR score of <F1, 2nd test must confirm chronic HCV diagnosis at least 6 months after 1st test.
   Prior pre-treatment viral load or antibody test: _____ Date Taken:_____
4. Does member have decompensated hepatic disease or moderate-to-severe hepatic impairment (Child-Pugh B or C)? Yes___ No___
5. Is the member currently on hospice or does the member have a limited life expectancy (less than 12 months) that cannot be remediated by treating HCV? Yes____ No____
6. Has the member been evaluated by a gastroenterologist, infectious disease specialist, or a transplant specialist within the past 3 months? Yes___ No___
7. If yes, please include name of specialist recommending hepatitis C treatment: _____
8. Has the member been previously treated for hepatitis C? Yes___ No___
9. Did the member's prior treatment regimen contain an NS5A inhibitor (e.g., daclatasvir, elbasvir, ledipasvir, ombitasvir, pibrentasvir, velpatasvir)? Yes___ No___
10. Did the member's prior treatment regimen contain an NS3/4A protease inhibitor (e.g., boceprevir, glecaprevir, grazoprevir, paritaprevir, simeprevir, telaprevir, voxilaprevir)? Yes___ No___
11. Please indicate previous treatment regimen and reason for failure (relapser, null-responder, partial responder):
    _____
12. Please indicate requested regimen below:
    - ❑ Mavyret™ 100mg/40mg daily x 56 days (8 weeks)
    - ❑ Mavyret™ 100mg/40mg daily x 84 days (12 weeks)
    - ❑ Mavyret™ 100mg/40mg daily x 112 days (16 weeks)
    - ❑ Other:_____
13. Has the member signed the intent to treat contract**? Yes___ No___ ***Required for processing of request*
14. Has the member been counseled on the harms of illicit IV drug use and alcohol use and agreed to not use illicit IV drugs or alcohol while on or after they finish hepatitis C treatment? Yes____ No____
15. Has the member initiated immunization with the hepatitis A and B vaccines? Yes___ No___
16. For women of childbearing potential (and male patients with female partners of childbearing potential):
    - ❑ Patient is not pregnant (or a male with a pregnant female partner) and not planning to become pregnant during treatment
    - ❑ Agreement that partners will use two forms of effective non-hormonal contraception during treatment. Please list non-hormonal birth control options discussed with member_____
17. Is the member taking any of the following medications: carbamazepine, rifampin, ethinyl estradiol containing medications, St. John's wort, atazanavir, darunavir, lopinavir, ritonavir, efavirenz, atorvastatin, lovastatin, simvastatin, rosuvastatin doses greater than 10mg, or cyclosporine doses greater than 100mg per day? Yes___ No___
18. Have all other clinically significant issues been addressed prior to starting therapy? Yes___ No___

❑ This patient is in need of additional support. I recommend this patient be followed by an OHCA Care Management Nurse.

Members must be adherent for continued approval. Treatment gaps of therapy longer than 3 days will result in denial of payment for subsequent requests for continued therapy. Refills must be prior authorized.

Prescriber Signature: _____ **Date:** _____

Has the member been counseled on appropriate use of Mavyret™ therapy? Yes___ No___

Pharmacist Signature: _____ **Date:** _____

Please do not send in chart notes. Failure to complete this form in full will result in processing delays. By signature, the prescriber or pharmacist confirms the above information is accurate.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:
University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4