Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Mavyret®

Phone: 215-991-4300 Fax back to: 866-240-3712

Health Partners Plans 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 (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP:	
	Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the patient over the age of 18?

☐ Yes ☐ No (please refer to Harvoni Prior Auth Criteria)

Q2. Does the patient have a short life expectancy that cannot be remediated by treating HCV, by transplantation, or by other directed therapy?

☐ Yes ☐ No

Q3. What is the patient's treatment history? Please select at least one of the following (Documentation must be attached):

☐ Treatment-naïve
☐ Treatment-experienced (PegIFN/RBV)
☐ Treatment-experienced (PegIFN/RBV/protease inhibitor)
☐ Treatment-experienced (NS5B inhibitor)
☐ Treatment-experienced (NS5A inhibitor)
☐ Other (please specify)

Q4. If the patient had previous HCV treatment what was the treatment outcome? Please select at least one of the following (Documentation must be attached):

☐ Did not complete treatment due to non-compliance with medications and/or HCV therapy management
☐ Did not complete treatment due to side effects and/or hospitalization
☐ Prior-Relapser (PegIFN/RBV)
☐ Protease inhibitor failure
☐ NS5B inhibitor failure
☐ NS5A inhibitor failure

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Patient Name:	**Prescriber Name:**

☐ Completed treatment and achieved sustained virologic response (SVR)
☐ Partial responder (PegIFN/RBV)
☐ Null responder (PegIFN/RBV)
☐ Other (please specify)

Q5. Has the provider addressed the cause of non-compliance with previous HCV therapy and provided a new treatment plan to correct or address treatment adherence?

☐ Yes ☐ No

Q6. Has the provider submitted a detectable quantitative HCV RNA that was tested within the past 12 weeks? (Labs must be attached)

☐ Yes ☐ No

Q7. What is the patient's genotype/subtype? Labs within the past 12 weeks must be attached. Please select at least one of the following:

☐ 1
☐ 2
☐ 3
☐ 4

Q8. Does the provider submit the following laboratory tests (done within the past 12 weeks)? (Labs must be attached)
A. Complete blood count (CBC)
B. International normalized ratio (INR)
C. Hepatic function panel (albumin, total and direct bilirubin, alanine aminotransferase, aspartate aminotransferase, and alkaline phosphatase levels)
D. Calculated glomerular filtration rate (GFR)
E. Fibrosis score/ Metavir stage
F. Hepatitis B screening (sAb/sAg and cAb/cAg)
G. HIV screening (HIV Ag/Ab)

☐ Yes ☐ No

Q9. Does the patient have documentation of a complete Hepatitis B immunization series? (Documentation must be attached)

☐ Yes ☐ No

Q10. Does the patient test positive for hepatitis BsAg? (Labs must be attached)

☐ Yes ☐ No

Q11. Does the patient have a detectable quantitative HBV DNA? (Labs must be attached)

☐ Yes ☐ No

Q12. Does the patient have a treatment plan for hepatitis B consistent with AASLD recommendations B? (Treatment plan must be attached)

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☐ Yes	☐ No
Q13. Does the patient test negative for hepatitis BsAb? (Labs must be attached)	
☐ Yes	☐ No
Q14. Does the patient have a hepatitis B immunization plan or counseling to receive the hepatitis B immunization series? (Documentation must be attached)	
☐ Yes	☐ No
Q15. Has the patient have a confirmed positive HIV-1/HIV-2 differentiation immunoassay? (Labs must be attached)	
☐ Yes	☐ No
Q16. Is the patient being treated for HIV? (Documentation must be attached)	
☐ Yes	☐ No
Q17. Has the prescriber submitted a medical record documents the rationale for not being treated?	
☐ Yes	☐ No
Q18. Does the patient have cirrhosis? Please select at least one of the following:	
☐ No	
☐ Yes, and compensated	
☐ Yes, and decompensated (Child-Pugh class B or C) (please refer to Epclusa Prior Auth Criteria)	
Q19. Does the patient have any contraindication to glecaprevir/pibrentasvir?	
☐ Yes	☐ No
Q20. Has patient's medication profiles been reviewed and shown any contraindicated drug interactions (Risk X) with glecaprevir/pibrentasvir?	
☐ Yes	☐ No
Q21. Has any plan been made to address the contraindicated drug-drug interactions, such as discontinuation, dose reduction of interacting drugs, counseling patient of the risks associated with the potentially significant drug-drug interaction?	
☐ Yes	☐ No
Q22. Does the patient have a history of chronic alcohol consumption or dependency?	
☐ Yes	☐ No
Q23. Does the provider submit documentation of counseling regarding the risks of alcohol consumption and offering referral for substance abuse or behavioral health (BH) treatment program?	
☐ Yes	☐ No

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Patient Name:	**Prescriber Name:**

Q24. Does the patient have a history of substance abuse/dependency or illicit drug use?

☐ Yes ☐ No

Q25. Does the provider submit documentation of counseling regarding the risk of illicit drug use and offering referral for substance abuse or behavioral health (BH) treatment program?

☐ Yes ☐ No

Q26. Does the patient have a history of mental or psychiatric disorders (such as, suicide, suicidal and homicidal ideation, depression, psychoses, schizophrenia, bipolar disorders, mania, anxiety disorder, relapse of drug addiction/overdose and aggressive behavior)?

☐ Yes ☐ No

Q27. Was the patient evaluated or treated by a psychiatrist or behavioral health specialist?

☐ Yes ☐ No

Q28. Is the patient willing to be treated and conform to treatment requirements (such as commitment to adherence with hepatitis C treatment course, referral to disease case management, hepatitis C educational/counseling and monitoring program including sustained virologic response (SVR) tracking and reporting)?

☐ Yes ☐ No

Q29. Does the patient have medication adherence issues in general (such as non-adherence to medications used to treat other existing or comorbid conditions)?

☐ Yes ☐ No

Q30. Is the patient currently treated with the drugs containing glecaprevir and/or pibrentasvir, or combination of drugs containing any other direct-acting antiviral (DAA)?

☐ Yes ☐ No

Q31. Requested Duration:

☐ 8 Weeks
☐ 12 Weeks
☐ 16 Weeks
☐ Other:_____

Q32. Additional Information:

Prescriber Signature Date

Sunray Specialty Pharmacy
Phone: 215-471-4000 x0 | Fax: 215-471-4001

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