HEALTH PLANS
UNIVERSITY OF UTAH

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 the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

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-preferred: ☐ 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
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. Has the member had a quantitative viral load obtained within the last 6 months?	☐	☐	**Please provide documentation**
4. Has the member's HCV genotype been obtained?	☐	☐	**Please provide documentation**
5. Is there documentation of Child-Pugh classification?	☐	☐	**Please provide documentation**
6. If the member is actively abusing alcohol or intravenous (IV) drugs, or has a history of abuse, has the member been counseled regarding the risks and offered a referral for substance abuse disorder?	☐	☐	**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. Does the member have other medical, psychosocial, or psychological comorbidity that could result in a life expectancy less than 1 year?	☐	☐	

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: 08/19/2020
Next Review Date: 08/19/2021
Current Effective Date: 09/01/2020