



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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.

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

Expedited/Urgent checkbox

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 checkbox

No (please refer to Harvoni Prior Auth Criteria) checkbox

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

Yes checkbox

No checkbox

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

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

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 checkbox
Did not complete treatment due to side effects and/or hospitalization checkbox
Prior-Relapser (PegIFN/RBV) checkbox
Protease inhibitor failure checkbox
NS5B inhibitor failure checkbox
NS5A inhibitor failure checkbox

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Patient Name:

Prescriber Name:

Completed treatment and achieved sustained virologic response (SVR)

Other (please specify)

Partial responder (PegIFN/RBV)

Null responder (PegIFN/RBV)

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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Patient Name:

Prescriber Name:

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 Eplusa 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 checkbox

No checkbox

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 checkbox

No checkbox

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 checkbox

No checkbox

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

Yes checkbox

No checkbox

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 checkbox

No checkbox

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 checkbox

No checkbox

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 checkbox

No checkbox

Q31. Requested Duration:

8 Weeks checkbox

12 Weeks checkbox

16 Weeks checkbox

Other: checkbox with blank line

Q32. Additional Information:

Prescriber Signature

Date

Updated 2018