Magellan COMPLETE CARE®

MAGELLAN COMPLETE CARE OF VIRGINIA – CCC PLUS

Service Authorization (SA) Form

HEPATITIS C ANTIVIRALS: NON-PREFERRED

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

If your request is for Mavyret™ or sofosbuvir/velpatasvir, please use **Hepatitis C Antivirals: Preferred** SA Form.

MEMBER INFORMATION

Last Name:

First Name:

Medicaid ID Number:

Date of Birth: ___ – ___ – ____

Gender: ☐ **Male** ☐ **Female**

Member Age: _____

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: ___ – ___ – ____

Fax Number: ___ – ___ – ____

Prescriber Specialty: Non-preferred hepatitis C medication must be prescribed by one of the following specialty physicians below or be in consultation with one of the following:

☐ Gastroenterologist ☐ Hepatologist ☐ Transplant Specialist ☐ Infectious Disease

☐ Other: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

 Revised: 04/09/2020 | Effective: 01/01/2020

Member's Last Name:

Member's First Name:

DIAGNOSIS (you may check more than one box)

☐ Chronic hepatitis C ☐ Compensated cirrhosis ☐ Hepatocellular carcinoma

☐ Decompensated cirrhosis (Child-Pugh score class B or C) ☐ Status post-liver transplant

☐ Severe renal impairment (eGFR <30 mL/min/1.73m^2) or end stage renal disease requiring hemodialysis

HCV Genotype:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

Choose One: ☐ Treatment initiation ☐ Continuation of therapy, current week: _____

PREVIOUS HEPATITIS C TREATMENTS

☐ **Treatment naïve**

☐ **Treatment experienced with (check all that apply):**

- ☐ Daklinza™ (daclatasvir)
- ☐ Epclusa® (sofosbuvir/velpatasvir)
- ☐ Harvoni® (ledipasvir-sofosbuvir)
- ☐ Incivek® (telaprevir)
- ☐ Interferon
- ☐ ledipasvir-sofosbuvir
- ☐ Olysio™ (simeprevir)
- ☐ peginterferon
- ☐ ribavirin
- ☐ sofosbuvir/velpatasvir
- ☐ Sovaldi® (sofosbuvir)
- ☐ Technivie® (ombitasvir/paritaprevir/ritonavir)
- ☐ Viekira Pak™ (ombitasvir/paritaprevir/ritonavir) with dasabuvir
- ☐ Viekira XR™ (ombitasvir/paritaprevir/ritonavir; dasabuvir)
- ☐ Zepatier™ (elbasvir and grazoprevir)

Document dates received: _____

_____ _____

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be faxed to **1-800-922-3986,** phoned to **1-800-424-4524 (TTY 711)** or mailed to:

Magellan Rx Management Prior Authorization Program

c/o Magellan Health, Inc.

11013 West Broad Street

Glen Allen, VA 23060

Magellan Complete Care of Virginia website: https://mccofva.com/

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