

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:

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**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.)*

Member's Last Name:

Grid for Member's Last Name

Member's First Name:

Grid for 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/1.73m²) 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 1-800-424-7581, phoned to 1-800-424-4518 (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 – Medallion 4.0 website: https://mccofva.com/