

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

Please use one form per member.

MEMBER INFORMATION

Last Name:

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First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Medicaid ID Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Birth:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Gender: Male Female

Member Age: _____

PRESCRIBER INFORMATION

Last Name:

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First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

NPI Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Fax Number:

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DRUG INFORMATION

*The preferred hepatitis C drugs listed below can be prescribed by a generalist without specialty consultation.

Mavyret™ sofosbuvir/velpatasvir

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name:

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Member's First Name:

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DIAGNOSIS

- Chronic hepatitis C Compensated cirrhosis Hepatocellular carcinoma
- Decompensated cirrhosis (Child-Pugh score class B or C) Status post-liver transplant

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

(For your information only) Hepatitis C Complexity review: If a patient meets any of these criteria, they may benefit from specialty consultation.

- Patient is coinfectd with Hepatitis B
- Patient is pregnant, breastfeeding or planning to breastfeed
- Patient is taking atazanavir or rifampin
- Patient has severe kidney problems or is on dialysis
- Patient has HIV
- Patient has severe decompensated liver cirrhosis or a Child-Pugh score class B or C

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