Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Mavyret - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

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.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

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. Does the patient have a diagnosis of chronic hepatitis C with supporting documentation?

☐ Yes ☐ No

Q2. Are the following baseline labs attached?
A. HCV genotype
B. Quantitative HCV RNA
C. Complete blood count (CBC)
D. International normalized ratio (INR)
E. Hepatic function panel (albumin, total and direct bilirubin, alanine aminotransferase, aspartate aminotransferase, and alkaline phosphatase levels)
F. Serum creatinine/calculated glomerular filtration rate
G. Transient elastography (such as FibroScan) or noninvasive serologic tests (such as FibroSure or calculate FIB-4 score)
H. Hepatitis B surface antigen (HBsAg)
I. HIV antigen/antibody test

☐ Yes ☐ No

Q3. Does the patient have moderate or severe hepatic impairment (Child-Pugh B or C) or any history of prior hepatic decompensation?

☐ Yes ☐ No

Q4. Does the patient have any other conditions that would fall under the exclusion criteria per current AASLD guidance?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. Requested Duration:

☐ 8 Weeks ☐ 12 Weeks ☐ 16 Weeks

Q6. Additional Information:

_____ _____

Prescriber Signature Date

2023 Medicare Prior Authorization Request