Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information	
Requested Drug(s) & Strength(s):	[ ] Mavyret 100 mg-40 mg tablet [ ] Mavyret 50 mg-20 mg oral pellets in packet
Requested Quantity Limit Over Time – Amount:	
Requested Quantity Limit Over Time – Days:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: What is the member's diagnosis? (Check only one that apply)

[ ] Chronic hepatitis C infection

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request)
_____(*Required)

Q3: Does the prescribed medication used in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]? (Check only one that apply)

[ ] Yes (please provide clinical rationale for the request) _____ (*Required)

[ ] No

Q4: Is the reqeusted medication prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, or HIV specialist certified through the American Academy of HIV Medicine? (Check only one that apply)

[ ] Yes (please specify prescriber specialty) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q5: Request is for one of the following (Check only one that apply)

[ ] Chronic hepatitis C infection without decompensated cirrhosis

[ ] Chronic hepatitis C-Genotype 1, 2, 3, 4, 5, or 6 with compensated cirrhosis

[ ] Chronic hepatitis C-Genotype 1, 2, 3, 4, 5, or 6 without cirrhosis

[ ] Other (please provide clinical rationale for the request) _____ (*Required)

Q6: What is the expected length of therapy? (Check only one that apply)

[ ] 8 weeks

[ ] 12 weeks

[ ] 16 weeks

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q7: Is the request for chronic hepatitis C-Genotype 1, 2, 3, 4, 5, or 6? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q8: Is the member treatment-naive? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q9: Is the request for any one of the following? (Check only one that apply)

[ ] Chronic hepatitis C-Genotype 1

[ ] Chronic hepatitis C-Genotype 1, 2, 3, 4, 5, or 6

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q10: Has the member had an inadequate response with a previous treatment regimen that included a HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)]? (Check only one that apply)

[ ] Yes (please specify drug name and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q11: Has the member had previous treatment experience with a treatment regimen that included an NS5A inhibitor (e.g., Daklinza [daclatasvir])? (Check only one that apply)

[ ] Yes (please provide clinical rationale for the request) _____
(*Required)

[ ] No

Q12: Member meets any one of the following? (Check only one that apply)

[ ] Member is not infected with HCV prior to receiving a liver transplant

[ ] Member has had a liver or kidney transplant

[ ] Other (please provide clinical rationale for the request) _____
(*Required)

Q13: Has the member had received a liver transplant from a donor with a diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q14: Is the request for any one of the following? (Check only one that apply)

[ ] Chronic hepatitis C-Genotype 1

[ ] Chronic hepatitis C-Genotype 3

[ ] Chronic hepatitis C-Genotype 1, 2, 3, 4, 5, or 6 _____(*Required)

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q15: Has the member had an inadequate response with a previous treatment regimen that included an NS5A inhibitor (e.g., Daklinza [daclatasvir])? (Check only one that apply)

[ ] Yes (please specify drug name and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] No

Q16: Has the member had previous treatment experience with a treatment regimen that included a HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)]? (Check only one that apply)

[ ] Yes (please provide clinical rationale for the request) _____
(*Required)

[ ] No

Q17: Has the member had an inadequate response with a previous treatment regimen that included interferon, peginterferon, ribavirin, and/or Sovaldi (sofosbuvir)? (Check only one that apply)

[ ] Yes (please specify drug name and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] No (please provide clinical rationale for the request)

Q18: Has the member had previous treatment experience with a treatment regimen that included a HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] or an NS5A inhibitor (e.g., Daklinza [daclatasvir])? (Check only one that apply)

[ ] Yes (please provide clinical rationale for the request) _____ (*Required)

[ ] No

Q19: Has the member had an inadequate response with one of the prior treatment? (Check only one that apply)

[ ] Sovaldi (sofosbuvir): (please specify the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] Vosevi (sofosbuvir/velpatasvir/voxilaprevir): (please specify the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q20: Has the member had previous treatment experience with a treatment regimen that included a HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] or an NS5A inhibitor (e.g., Daklinza [daclatasvir])? (Check only one that apply)

[ ] Yes (please provide clinical rationale for the request) _____ (*Required)

[ ] No

Q21: Does the prescribed medication used in combination with Sovaldi (sofosbuvir) and ribavirin? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q22: Has the member had an inadequate response with a previous interferon-based treatment regimen? (Check only one that apply)

[ ] Yes (please specify drug name and the start and end date(s) of therapy (month/year))

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q23: Has the member had any previous treatment experience with a treatment regimen that included a HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] or an NS5A inhibitor (e.g., Daklinza [daclatasvir])? (Check only one that apply)

[ ] Yes (please specify drug name and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] No

Q24: Has the member had an inadequate response with a previous interferon-based treatment regimen? (Check only one that apply)

[ ] Yes (please specify drug name, intolerance experienced and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] No

Q25: Has the member had any previous treatment experience with a treatment regimen that included a HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] or an NS5A inhibitor (e.g., Daklinza [daclatasvir])? (Check only one that apply)

[ ] Yes (please specify drug name and the start and end date(s) of therapy (month/year))
_____(*Required)

[ ] No

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the HealthPlan, Insurer, Medical Group or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	
Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	