State of Maine Department of Health & Human Services
MaineCare/MEDEL Prior Authorization Form
HEPATITIS C TREATMENT

Phone: 1-888-445-0497 www.mainecarepdl.org Fax: 1-888-879-6938

Member ID #: |__|__|__|__|__|__|__|__|__|__|__| Patient Name: _____ DOB: _____
(NOT MEDICARE NUMBER)
Patient Address: _____

Provider DEA: |__|__|__|__|__|__|__|__|__|__|__| Provider NPI: |__|__|__|__|__|__|__|__|__|__|

Provider Name: _____ Phone: _____

Provider Address: _____ Fax: _____

Pharmacy Name: _____ Rx Address: _____ Rx Phone: _____

Provider must fill all information above. It must be legible, correct and complete or form will be returned.

(Pharmacy use only): NPI: |__|__|__|__|__|__|__|__|__|__| NABP: |__|__|__|__|__|__|__| NDC: |__|__|__|__|__|__|__|__|__|__|__|

Prior Authorization is <u>not required</u> for the following simplified treatments:

- **Mavyret (glecaprevir/pibrentasvir) 100/40 mg; three (3) tablets daily for 56 days (8 weeks)**
- **Sofosbuvir/velpatasvir 400/100 mg daily for 84 days (12 weeks)**

<u>WHO IS *NOT* ELIGIBLE FOR SIMPLIFIED TREATMENT</u>:

- Prior hepatitis C treatment
- Cirrhosis
- Hepatitis B Surface Antigen positive
- Current pregnancy
- Known or suspected hepatocellular carcinoma
- Prior liver transplantation
- Mavyret treatment duration greater than 8 weeks
- Sofosbuvir/velpatasvir treatment duration greater than 12 weeks

<u>Non-Preferred (PA required):</u>

- ❑ **Mavyret Oral Pellets**
  - ❑ **Weight <20 kg Three 50/20mg packets daily**
  - ❑ **Weight 20 - < 30kg Four 50/20mg packets daily**
  - ❑ **Weight 30 - <45kg Five 50/20mg packets daily**
- ❑ **Mavyret (**regimens > 8 weeks**)**
- ❑ **Sofosbuvir/velpatasvir (**regimens > 12 weeks**)**
- ❑ **Vosevi**
- ❑ **Other:** _____

Dosage Instructions	**Quantity**	**Days Supply**	**Total Duration**
_____	_____	_____	_____**weeks**

Clinical Rationale for use of selected regimen (may include genotype, prior treatment history, cirrhosis level, reason for RBV ineligibility, etc.)**:** _____

_____

_____

_____

The prescriber can attest and medical records document that the following are true:

- ❑ Prescriber is, or has consulted within the past year with, a gastroenterologist, hepatologist, ID specialist or other Hepatitis specialist
- ❑ Patient does not have a life expectancy less than 12 months due to non-liver related comorbidities
- ❑ Negative pregnancy test within 60 days of request in women of childbearing age
- ❑ Provider has checked for drug interactions
- ❑ Labs performed within the past 6 months include:
  - ❑ Quantitative HCV RNA viral load
  - ❑ Fibrosis score
  - ❑ CBC
  - ❑ Hepatic function panel
  - ❑ Calculated GFR
  - ❑ Hepatitis B surface antigen
  - ❑ Child-Turcotte-Pugh (CTP) Score

PEDIATRIC NOTE: FDA-approved pediatric formulations will be authorized for treatment-naïve children aged 3 years and older without prior authorization when used in accordance with the simplified treatment regimen. For children under age 3, or for those who are not treatment-naïve or have complex clinical circumstances (e.g., cirrhosis), treatment must follow current AASLD guidelines regarding indication and age. In these cases, prior authorization is required.

Pursuant to the MaineCare Benefits Manual, Chapter I, Section 1.16, The Department regards adequate clinical records as essential for the delivery of quality care, such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessary, meets the MaineCare criteria for prior authorization, does not exceed the medical needs of the member and is supported in your medical records.

Provider Signature: _____ **Date of Submission:** _____

***MUST MATCH PROVIDER LISTED ABOVE**