Health Partners Plans

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. Is the patient 12 years of age and older or weighing at least 45 kg?

☐ Yes ☐ No

Q2. Is the patient:

☐ Treatment-experienced: Please submit documentation of previous regimen, dates, lab work, and treatment outcome] ☐ Treatment-naive

Q3. Does the patient have a diagnosis of chronic hepatitis C with supporting documentation?

☐ Yes ☐ No

Q4. Are the following baseline labs attached? [Note - Must be attached for approval]

A. HCV genotype and subtype
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. Liver biopsy or other indirect markers (such as FibroTest or Fibroscan)
H. HBsAg, anti-HBc, anti-HBs
I. HIV antigen/antibody test

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q5. Does the patient have moderate or severe hepatic impairment (Child-Pugh B or C) or any history of prior hepatic decompensation?

☐ Yes ☐ No

Q6. Does the patient have any other conditions that would fall under the exclusion criteria per current AASLD guidance?

☐ Yes ☐ No

Q7. Additional Information:

Q8. Requested Duration:

☐ 8 weeks ☐ 12 weeks ☐ 16 weeks

Prescriber Signature

Date

2021 Medicare Prior Authorization Request