PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS

Mavyret - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Mavyret - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Mavyret (glecaprevir-pibrentasvir)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Does the patient have a diagnosis of chronic hepatitis C (HCV)? Y N

NOTE: Submission of medical records is required.

[If no, no further questions.]

2. Has the patient had hepatitis C (HCV) infection for 6 months or greater? Y N

	[If no, no further questions.]		
3.	Has chronic disease been supported by one of the following: A) lab testing such as an HCV antibody or HCV RNA test completed 6 months apart, B) HCV diagnosis documented in prescribers' note from the past office visit(s), or C) exposure risk history documented in prescribers' notes from the past office visit(s)?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
4.	Has the patient's genotype and subtype been determined?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
5.	Has the patient undergone a liver biopsy or another accepted test that has demonstrated a liver fibrosis status?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
6.	Does the patient have a diagnosis of cirrhosis?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, skip to question 9.]		
7.	Has clinical documentation showing support for the diagnosis, prior hepatitis C treatment history and treatment response (Relapsed, Partial Responder, Non-Responder, Toxicity, or Reinfection), and a planned treatment been submitted and dated within 90 days of the prior authorization request?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
8.	Does the patient have baseline laboratory values including HCV RNA level, total bilirubin, albumin, and INR, within 90 days of prior authorization request?	Y N	
	NOTE: Submission of medical records is required.		
	[If yes, skip to question 11.]		
	[If no, no further questions.]		
9.	Has clinical documentation showing support for the diagnosis, prior hepatitis C treatment history and treatment response (Relapsed, Partial Responder, Non-Responder, Toxicity, or Reinfection), and a planned treatment been submitted and dated within 180 days of the prior authorization request?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
10.	Does the patient have a baseline HCV RNA level within 180 days of prior authorization request?	Y N	

NOTE: Submission of medical records is required.		
[If no, no further questions.]		
11. Is the patient HIV positive?	Y N	
[If no, skip to question 13.]		
12. Has the patient's current antiretroviral regimen and degree of viral suppression been documented within 180 days prior to the request?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
13. Does the patient have active HBV disease?	Y N	
[If no, skip to question 15.]		
14. Has the patient's current antiretroviral regimen and degree of viral suppression been documented within 180 days prior to the request?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
15. Has a treatment plan been developed and discussed with patient?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
16. Is the patient 3 years of age or older?	Y N	
[If no, no further questions.]		
17. Has the patient previously been treated with glecaprevir and pibrentasvir?	Y N	
[If yes, no further questions.]		
18. Is the patient treatment naive?	Y N	
[If no, skip to question 22.]		
19. Does the patient have a HCV genotype of genotype 1, 2, 3, 4, 5, or 6?	Y N	
[If no, no further questions.]		
20. Does the patient meet any of the following: A) no cirrhosis, OR B) compensated cirrhosis (Child-Pugh A)?	Y N	
[If no, no further questions]		
21. Is the requested duration of therapy greater than 8 weeks?	Y N	
[No further questions.]		
22. Does the treatment-experienced patient have a HCV genotype of 1?	Y N	
[If no, skip to question 36.]		
23. Has the patient previously been treated with a regimen containing an NS5A inhibitor* without prior treatment with an NS3/4A protease inhibitor (PI)?	Y N	

NOTE: *Treated with prior regimens containing ledipasvir and sofosbuvir or daclatasvir with (peg) interferon and ribavirin.	
[If no, skip to question 27.]	
24. Does the patient have cirrhosis?	Y N
[If no, skip to question 26.]	
25. Does the patient have compensated cirrhosis (Child-Pugh A)?	Y N
[If no, no further questions.]	
26. Is the requested duration of therapy greater than 16 weeks?	Y N
[No further questions.]	
27. Has the patient previously been treated with a regimen containing an NS3/4A PI* without prior treatment with an NS5A inhibitor?	Y N
NOTE: *Treated with prior regimens containing simeprevir and sofosbuvir, or simeprevir, boceprevir, or telaprevir with (peg) interferon and ribavirin.	
[If no, skip to question 31.]	
28. Does the patient have cirrhosis?	Y N
[If no, skip to question 30.]	
29. Does the patient have compensated cirrhosis (Child-Pugh A)?	Y N
[If no, no further questions.]	
30. Is the requested duration of therapy greater than 12 weeks?	Y N
[No further questions.]	
31. Has the patient previously been treated with a regimen containing a (peg) interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A PI or NS5A inhibitor?	Y N
[If no, no further questions.]	
32. Does the patient have cirrhosis?	Y N
[If yes, skip to question 34.]	
33. Is the requested duration of therapy greater than 8 weeks?	Y N
[No further questions.]	
34. Does the patient have compensated cirrhosis (Child-Pugh A)?	Y N
[If no, no further questions]	
35. Is the requested duration of therapy greater than 12 weeks?	Y N
[No further questions.]	
36. Does the treatment-experience patient have a HCV genotype of 2, 4, 5, or 6?	Y N

[If no, skip to question 42.]	
37. Has the patient previously been treated with a regimen containing a (peg) interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A PI or NS5A inhibitor?	Y N
[If no, no further questions]	
38. Does the patient have cirrhosis?	Y N
[If yes, skip to question 40.]	
39. Is the requested duration of therapy greater than 8 weeks?	Y N
[No further questions.]	
40. Does the patient have compensated cirrhosis (Child-Pugh A)?	Y N
[If no, no further questions.]	
41. Is the requested duration of therapy greater than 12 weeks?	Y N
[No further questions.]	
42. Does the treatment-experienced patient have a HCV genotype of 3?	Y N
[If no, no further questions.]	
43. Has the patient previously been treated with a regimen containing a (peg) interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A PI or NS5A inhibitor?	Y N
[If no, no further questions.]	
44. Does the patient meet any of the following: A) no cirrhosis, OR B) compensated cirrhosis (Child-Pugh A)?	Y N
[If no, no further questions.]	
45. Is the requested duration of therapy greater than 16 weeks?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date