Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Hepatitis C: Mavyret

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: **Mavyret** 2. Strength: _____ 3. Quantity per 30 Days: **84**
4. Length of Therapy (in days): ☐ 8 Weeks ☐ 12 Weeks ☐ 16 Weeks

Clinical Information

Total Length of Therapy (Check ONE):

☐ **8 weeks** = All genotypes: without cirrhosis or with compensated cirrhosis (Child Pugh-A)

☐ **12 weeks** = Treatment naïve patients with a Liver or Kidney transplant recipients, or treatment-experienced patients with HCV Genotype 1 and previously treated with a regimen containing an NS3/4A PI_2 without prior treatment with an NS5A inhibitor

☐ **16 weeks** = Recipients with an HCV Genotype 1 and previous treated with a regimen containing an NS5A inhibitor without prior treatment with an NS3/4A protease inhibitor (including liver or kidney transplant recipients) or a recipient with an HCV Genotype 3 and previously treated with a regimen containing PRS3 (including liver or kidney transplant recipients).

1. Is the member 3 years of age or older with a diagnosis of chronic hepatitis C (CHC) with genotype 1,2,3,4,5, or 6?
   ☐ **Yes** ☐ **No Genotype is**: _____ (documentation of genotype waived if treatment naïve patient)
2. Does the member have cirrhosis? ☐ **Yes** ☐ **No Child-Pugh is: _____**
3. Are medical records documenting the diagnosis of chronic hepatitis C with genotype and subtype being submitted with this request? ☐ **Yes** ☐ **No** ****Lab test results MUST be attached to the PA to be approved.**** (documentation of genotype waived if treatment naïve patient
4. Does the member have a documented quantitative HCV RNA at baseline that was tested within the past 6 months (medical documentation required)? ☐ **Yes** ☐ **No** HCV RNA (IU/ml): _____ and/or log10 value: _____
5. As the provider, are you reasonably certain that treatment will improve the member's overall health status?
   ☐ **Yes** ☐**No**
6. Does the Member have an FDA labeled contraindications to Mavyret? ☐ **Yes** ☐ **No**
7. Is Marlet being used in combination with atazanavir and rifampin? ☐ **Yes** ☐ **No**
8. Does the Member have moderate to severe hepatic impairment (Child-Pugh B or C)? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277