



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit go.covermymeds.com/OptumRx to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Mavyret™ Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
<input type="checkbox"/> Chronic hepatitis C virus (HCV)					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information:					
Document the patient's hepatitis C virus (HCV) genotype:* _____					
Will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has a diagnosis of HCV genotype 1, 2, 3, 4, 5, or 6?* <input type="checkbox"/> Yes <input type="checkbox"/> No					
*Please note: Chart documentation of the above is required to be submitted along with this fax.					
Select if Mavyret is prescribed by or in consultation with one of the following specialists:					
<input type="checkbox"/> Gastroenterologist		<input type="checkbox"/> HIV specialist certified through the American Academy of HIV Medicine			
<input type="checkbox"/> Hepatologist		<input type="checkbox"/> Infectious Disease Specialist			
Select the patient's treatment experience below:					
<input type="checkbox"/> The patient is treatment-naïve					
<input type="checkbox"/> The patient has experienced treatment failure with a previous treatment regimen that included interferon, peginterferon, ribavirin, and/or Sovaldi (sofosbuvir)					
<input type="checkbox"/> The patient has experienced treatment failure with a previous treatment regimen that included a HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)]					
<input type="checkbox"/> The patient has experienced previous treatment failure with a treatment regimen that included an NS5A inhibitor [e.g., Daklinza (daclatasvir)]					
Does the patient have cirrhosis? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have decompensated liver disease (e.g., Child-Pugh Class B or C)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Will the patient be receiving Mavyret in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Quantity Limit Requests:					
What is the quantity requested per DAY? _____					
What is the reason for exceeding the plan limitations?					
<input type="checkbox"/> Titration or loading dose purposes					
<input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)					
<input type="checkbox"/> Requested strength/dose is not commercially available					
<input type="checkbox"/> Other: _____					

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

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Mavyret™ Prior Authorization Request Form (Page 2 of 2)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note:

This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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