MOLINA HEALTHCARE
Service Authorization (SA) Form
HEPATITIS C ANTIVIRALS, NON-PREFERRED

If the following information is not complete, correct, or legible, the SA process can be delayed. Please use one form per member.

Mavyret®, Mavyret® pellet pack or sofosbuvir/velpatasvir are preferred no PA required

MEMBER INFORMATION

Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐

First Name: ☐☐☐☐☐☐☐☐☐☐☐☐

Medicaid ID Number: ☐☐☐☐☐☐☐☐☐☐☐☐

Date of Birth: ☐☐ – ☐☐ – ☐☐☐☐

Gender: ☐ **Male** ☐ **Female**

Member Age: ____________________

PRESCRIBER INFORMATION

Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐

First Name: ☐☐☐☐☐☐☐☐☐☐☐☐

NPI Number: ☐☐☐☐☐☐☐☐☐☐

Phone Number: ☐☐☐ – ☐☐☐ – ☐☐☐☐

Fax Number: ☐☐☐ – ☐☐☐ – ☐☐☐☐

Prescriber Specialty: Non-preferred hepatitis C medication must be prescribed by one of the following specialty physicians below or be in consultation with one of the following:

☐ Gastroenterologist ☐ Hepatologist ☐ Transplant specialist ☐ Infectious disease

☐ Other: ____________________

DRUG INFORMATION

Drug Name/Form: ____________________

Strength: ____________________

Dosing Frequency: ____________________

Length of Therapy: ____________________

Quantity per Day: ____________________

(Form continued on next page.)

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Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

DIAGNOSIS (you may check more than one box)

☐ Acute or chronic hepatitis C ☐ Compensated cirrhosis ☐ Hepatocellular carcinoma

☐ Decompensated cirrhosis (Child-Pugh score class B or C) ☐ Status post-liver transplant

☐ Severe renal impairment (eGFR < 30 mL/min/1.73 m^2) or end stage renal disease requiring hemodialysis

HCV Genotype:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

Choose One: ☐ Treatment initiation ☐ Continuation of therapy, current week:

PREVIOUS HEPATITIS C TREATMENTS

☐ **Treatment naïve**

☐ **Treatment experienced (please list treatment)**

____

____

Document dates received: ______________________________

______________________________ ______________

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by Molina Healthcare.

The completed form may be **faxed to 1-844-278-5731**, or you may call (800) 424-4518.

TTY/TDD: 711)

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