



PRIOR AUTHORIZATION REQUEST

HEPATITIS C

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number:	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength:	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL PA requests**. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

- 1
- What medication is being requested?
- ☐ Mavyret (If checked, go to 2)
- ☐ Sofosbuvir-Velpatasvir (If checked, go to 35)
- ☐ Vosevi (If checked, go to 50)
- ☐ Ledipasvir-sofosbuvir (If checked, no further questions)

If you have any
questions, call:
1-888-258-8250

Version 10.2026

PRIOR AUTHORIZATION REQUEST

☐ Zepatier (If checked, no further questions)

☐ Other (If checked, no further questions)

2	Is the patient 3 years of age or older? [If no, no further questions.]	Yes	No
3	Does the patient have a diagnosis of chronic hepatitis C infection? [Note: persistent and detectable serum hepatitis C virus (HCV) ribonucleic acid (RNA) for a period greater than or equal to 6 months.] [If no, no further questions.]	Yes	No
4	Has documentation of serum hepatitis C virus (HCV) ribonucleic acid (RNA), liver function labs (ALT/AST/albumin/ total bilirubin/INR) obtained within the last 90-days been submitted? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
5	Has documentation been provided to show the patient has undergone a liver biopsy or non-invasive test to evaluate liver fibrosis status? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
6	Does the patient have an active hepatitis B virus (HBV) infection? ACTION REQUIRED: Submit supporting documentation. [If no, skip to question 8.]	Yes	No
7	Does the provider attest to monitor for HBV reactivation? [If no, no further questions.]	Yes	No
8	Does the provider attest that the patient hasn't been diagnosed with a comorbid condition that could result in a limited life expectancy? [Note: Life expectancy is less than 12 months at time of treatment request.] [If no, no further questions.]	Yes	No
9	Does any of the following apply to the patient? ☐ Post kidney or liver transplant infection/reactivation (if checked, go to 30) ☐ No history of kidney or liver transplant (if checked, go to 10)		
10	Is the patient treatment naive? [Note: Patient has not been treated with peginterferon alfa/ribavirin, an HCV NS3/4A protease inhibitor or NS5A inhibitor.] [If yes, skip to question 12.]	Yes	No
11	Is the patient treatment experienced? [Note: Patient has been treated with peginterferon alfa/ribavirin, an HCV NS3/4A	Yes	No

**If you have any
questions, call:
1-888-258-8250**

Version 10.2026

PRIOR AUTHORIZATION REQUEST

protease inhibitor or NS5A inhibitor.]
[If yes, skip to question 15.]

12 What is the patient's genotype? ACTION REQUIRED: Submit supporting documentation.

☐ Genotype 1 (If checked, go to 13)

☐ Genotype 2 (If checked, go to 13)

☐ Genotype 3 (If checked, go to 13)

☐ Genotype 4 (If checked, go to 13)

☐ Genotype 5 (If checked, go to 13)

☐ Genotype 6 (If checked, go to 13)

☐ Other (If checked, no further questions)

13 What is the patient's current liver status?

☐ No Cirrhosis (If checked, go to 14)

☐ Compensated cirrhosis [Child-Pugh A] (If checked, go to 14)

☐ Other (if checked, no further questions)

14 Will the requested duration of treatment exceed 8 weeks?
[No further questions.]

Yes No

15 Has the patient been previously treated with a regimen containing (peg)interferon, ribavirin and/or sofosbuvir without prior treatment with an NS3/4A protease inhibitor or NS5A inhibitor? ACTION REQUIRED: Submit supporting documentation.
[If yes, skip to question 18.]

Yes No

16 Has the patient been previously treated with a regimen containing an NS5A inhibitor without prior treatment with an NS3/4A protease inhibitor? ACTION REQUIRED: Submit supporting documentation.
[If yes, skip to question 24.]

Yes No

17 Has the patient been previously treated with a regimen containing an NS3/4A protease inhibitor without prior treatment with an NS5A inhibitor? ACTION REQUIRED: Submit supporting documentation.
[If yes, skip to question 27.]
[If no, no further questions.]

Yes No

**If you have any
questions, call:
1-888-258-8250**

Version 10.2026

PRIOR AUTHORIZATION REQUEST

- 18 What is the patient's genotype? ACTION REQUIRED: Submit supporting documentation.
- ☐ Genotype 1 (If checked, go to 19)
 - ☐ Genotype 2 (If checked, go to 19)
 - ☐ Genotype 3 (If checked, go to 22)
 - ☐ Genotype 4 (If checked, go to 19)
 - ☐ Genotype 5 (If checked, go to 19)
 - ☐ Genotype 6 (If checked, go to 19)
 - ☐ Other (If checked, no further questions)
- 19 What is the patient's current liver status?
- ☐ No Cirrhosis (If checked, go to 20)
 - ☐ Compensated cirrhosis [Child-Pugh A] (If checked, go to 21)
 - ☐ Other (If checked, no further questions)
- 20 Will the requested duration of treatment exceed 8 weeks? Yes No
[No further questions.]
- 21 Will the requested duration of treatment exceed 12 weeks? Yes No
[No further questions.]
- 22 What is the patient's current liver status?
- ☐ No Cirrhosis (If checked, go to 23)
 - ☐ Compensated cirrhosis [Child-Pugh A] (If checked, go to 23)
 - ☐ Other (If checked, no further questions)
- 23 Will the requested duration of treatment exceed 16 weeks? Yes No
[No further questions.]
- 24 What is the patient's genotype? ACTION REQUIRED: Submit supporting documentation.
- ☐ Genotype 1 (If checked, go to 25)
 - ☐ Genotype 2 (If checked, no further questions)

PRIOR AUTHORIZATION REQUEST

☐ Genotype 3 (If checked, no further questions)

☐ Genotype 4 (If checked, no further questions)

☐ Genotype 5 (If checked, no further questions)

☐ Genotype 6 (If checked, no further questions)

☐ Other (If checked, no further questions)

25 What is the patient's current liver status?

☐ No Cirrhosis (If checked, go to 26)

☐ Compensated cirrhosis [Child-Pugh A] (If checked, go to 26)

☐ Other (If checked, no further questions)

26 Will the requested duration of treatment exceed 16 weeks?
[No further questions.]

Yes No

27 What is the patient's genotype? ACTION REQUIRED: Submit supporting documentation.

☐ Genotype 1 (If checked, go to 28)

☐ Genotype 2 (If checked, no further questions)

☐ Genotype 3 (If checked, no further questions)

☐ Genotype 4 (If checked, no further questions)

☐ Genotype 5 (If checked, no further questions)

☐ Genotype 6 (If checked, no further questions)

☐ Other (If checked, no further questions)

28 What is the patient's current liver status?

☐ No Cirrhosis (If checked, go to 29)

☐ Compensated cirrhosis [Child-Pugh A] (If checked, go to 29)

☐ Other (If checked, no further questions)

29 Will the requested duration of treatment exceed 12 weeks?

Yes No

**If you have any
questions, call:
1-888-258-8250**

Version 10.2026

PRIOR AUTHORIZATION REQUEST

[No further questions.]

- | | | | |
|----|---|-----|----|
| 30 | <p>What is the patient's genotype? ACTION REQUIRED: Submit supporting documentation.</p> <p>☐ Genotype 1 (If checked, go to 31)</p> <p>☐ Genotype 2 (If checked, go to 33)</p> <p>☐ Genotype 3 (If checked, go to 32)</p> <p>☐ Genotype 4 (If checked, go to 33)</p> <p>☐ Genotype 5 (If checked, go to 33)</p> <p>☐ Genotype 6 (If checked, go to 33)</p> <p>☐ Other (If checked, no further questions)</p> | | |
| 31 | <p>Has the patient been previously treated with a regimen containing an NS5A inhibitor without prior treatment with an NS3/4A protease inhibitor? ACTION REQUIRED: Submit supporting documentation.</p> <p>[If no, skip to question 33.]</p> <p>[If yes, skip to question 34.]</p> | Yes | No |
| 32 | <p>Has the patient been previously treated with a regimen containing (peg)interferon, ribavirin and/or sofosbuvir without prior treatment with an NS3/4A protease inhibitor or NS5A inhibitor? ACTION REQUIRED: Submit supporting documentation.</p> <p>[If yes, skip to question 34.]</p> | Yes | No |
| 33 | <p>Will the requested duration of treatment exceed 12 weeks?</p> <p>[No further questions.]</p> | Yes | No |
| 34 | <p>Will the requested duration of treatment exceed 16 weeks?</p> <p>[No further questions.]</p> | Yes | No |
| 35 | <p>Is the patient 3 years of age or older?</p> <p>[If no, no further questions.]</p> | Yes | No |
| 36 | <p>Does the patient have a diagnosis of chronic hepatitis C infection?</p> <p>[Note: persistent and detectable serum hepatitis C virus (HCV) RNA for a period greater than or equal to 6 months.]</p> <p>[If no, no further questions.]</p> | Yes | No |
| 37 | <p>Has documentation of serum HCV RNA, liver function labs (ALT/AST/albumin/total bilirubin/INR) obtained within the last 90-days been submitted? ACTION REQUIRED: Submit supporting documentation.</p> | Yes | No |

**If you have any
questions, call:
1-888-258-8250**

Version 10.2026

PRIOR AUTHORIZATION REQUEST

[If no, no further questions.]

- | | | | |
|----|---|-----|----|
| 38 | Has documentation been provided to show the patient has undergone a liver biopsy or non-invasive test to evaluate liver fibrosis status? ACTION REQUIRED: Submit supporting documentation.
[If no, no further questions.] | Yes | No |
| 39 | Does the patient have an active hepatitis B virus (HBV) infection? ACTION REQUIRED: Submit supporting documentation.
[If no, skip to question 41.] | Yes | No |
| 40 | Does the provider attest to monitor for HBV reactivation?
[If no, no further questions.] | Yes | No |
| 41 | Does the provider attest that the patient hasn't been diagnosed with a comorbid condition that could result in a limited life expectancy?
[Note: Life expectancy is less than 12 months at time of treatment request.]
[If no, no further questions.] | Yes | No |
| 42 | Does any of the following apply to the patient?

☐ Post kidney or liver transplant infection/reactivation (If checked, go to 47)

☐ No history of kidney or liver transplant (If checked, go to 43) | | |
| 43 | Is the patient treatment naive?
[Note: Patient has not been treated with peginterferon alfa/ribavirin, an HCV NS3/4A protease inhibitor or NS5A inhibitor.]
[If yes, skip to question 45.] | Yes | No |
| 44 | Is the patient treatment experienced?
[Note: Patient has been treated with peginterferon alfa/ribavirin or an HCV NS3/4A protease inhibitor.]
[If no, no further questions.] | Yes | No |
| 45 | What is the patient's genotype? ACTION REQUIRED: Submit supporting documentation.

☐ Genotype 1 (If checked, go to 46)

☐ Genotype 2 (If checked, go to 46)

☐ Genotype 3 (If checked, go to 46)

☐ Genotype 4 (If checked, go to 46)

☐ Genotype 5 (If checked, go to 46) | | |

**If you have any
questions, call:
1-888-258-8250**

Version 10.2026

PRIOR AUTHORIZATION REQUEST

☐ Genotype 6 (If checked, go to 46)

☐ Other (If checked, no further questions)

46 What is the patient's current liver status?

☐ No Cirrhosis (If checked, go to 47)

☐ Compensated cirrhosis [Child-Pugh A] (If checked, go to 47)

☐ Decompensated cirrhosis [Child-Pugh B or C] (If checked, go to 48)

☐ Other (if checked, no further questions)

47	Will the requested duration of treatment exceed 12 weeks? [No further questions.]	Yes	No
----	--	-----	----

48	Will the requested duration of treatment exceed 12 weeks? [If yes, no further questions.]	Yes	No
----	--	-----	----

49	Will the patient be prescribed concomitant ribavirin therapy for 12 weeks? [No further questions.]	Yes	No
----	---	-----	----

50	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
----	--	-----	----

51	Does the patient have a diagnosis of chronic hepatitis C infection? [Note: Persistent and detectable serum hepatitis C virus (HCV) RNA for a period greater than or equal to 6 months.] [If no, no further questions.]	Yes	No
----	--	-----	----

52	Has documentation of serum HCV RNA, liver function labs (ALT/AST/albumin/total bilirubin/INR) obtained within the last 90-days been submitted? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
----	--	-----	----

53	Has documentation been provided to show the patient has undergone a liver biopsy or non-invasive test to evaluate liver fibrosis status? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
----	--	-----	----

54	Does the patient have an active hepatitis B virus (HBV) infection? ACTION REQUIRED: Submit supporting documentation. [If no, skip to question 56.]	Yes	No
----	---	-----	----

55	Does the provider attest to monitor for HBV reactivation? [If no, no further questions.]	Yes	No
----	---	-----	----

**If you have any
questions, call:
1-888-258-8250**

Version 10.2026

PRIOR AUTHORIZATION REQUEST

56	Does the provider attest that the patient hasn't been diagnosed with a comorbid condition that could result in a limited life expectancy? [Note: Life expectancy is less than 12 months at time of treatment request.] [If no, no further questions.]	Yes	No
57	What is the patient's current liver status? ☐ No Cirrhosis (If checked, go to 58) ☐ Compensated cirrhosis [Child-Pugh A] (If checked, go to 58) ☐ Other (If checked, no further questions)		
58	Has the patient been previously treated with a regimen containing an NS5A inhibitor? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 60.]	Yes	No
59	Has the patient been previously treated with a regimen containing sofosbuvir without prior treatment with an NS5A inhibitor? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 62.] [If no, no further question.]	Yes	No
60	What is the patient's genotype? ACTION REQUIRED: Submit supporting documentation. ☐ Genotype 1 (If checked, go to 61) ☐ Genotype 2 (If checked, go to 61) ☐ Genotype 3 (If checked, go to 61) ☐ Genotype 4 (If checked, go to 61) ☐ Genotype 5 (If checked, go to 61) ☐ Genotype 6 (If checked, go to 61) ☐ Other (If checked, no further questions)		
61	Will the requested duration of treatment exceed 12 weeks? [No further questions.]	Yes	No
62	What is the patient's genotype? ACTION REQUIRED: Submit supporting documentation. ☐ Genotype 1a (If checked, go to 63)		



PRIOR AUTHORIZATION REQUEST

☐ Genotype 1b (If checked, no further questions)

☐ Genotype 2 (If checked, no further questions)

☐ Genotype 3 (If checked, go to 63)

☐ Genotype 4 (If checked, no further questions)

☐ Genotype 5 (If checked, no further questions)

☐ Genotype 6 (If checked, no further questions)

☐ Other (If checked, no further questions)

63 Will the requested duration of treatment exceed 12 weeks? Yes No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE

DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any
questions, call:
1-888-258-8250

Version 10.2026