



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:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Medicaid ID Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Gender: ☐ Male ☐ Female

First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Birth:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Member Age: _____

PRESCRIBER INFORMATION

Last Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

NPI Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Fax Number:

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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.)

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 m²) 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 the number below.

- **CCC Plus:** (800) 424-4524 (TTY/TDD: 711)
- **Medallion 4.0:** (800) 424-4518 (TTY/TDD: 711)