

OPTIMA FAMILY CARE MEDALLION 4.0

Hepatitis C Therapy Patient Treatment Agreement

Prescriber Instructions: *Please submit the completed agreement with the initial prior authorization requests.*

Patient Instructions: By reading and signing this agreement, I acknowledge that I have been informed about the requirements of the treatment program and understand what is expected of me. I can refuse to sign this agreement, but treatment will not be started until and unless I sign this agreement.

Patient Information	Prescriber Information
Name: _____ _____	Name: _____ _____
Optima Health Member ID Number: _____	Optima Provider ID Number or NPI: _____
Date of Birth: _____	Office Contact Name: _____
Hepatitis C Medication Regimen: _____ _____	Telephone Number: _____ Fax Number: _____
1. I have been told how to take my hepatitis C medicines. I understand how to take them. I am aware of possible side effects. I understand why it is important to finish all the therapy.	
2. I will take my hepatitis C medicines like my doctor said. I understand that missing doses of medicine may cause the treatment to fail.	
3. I understand that if I miss more than 3 doses in one month, Medicaid may no longer pay for my hepatitis C medicines.	
4. I will tell my doctor and pharmacist the medicines I take. I understand there may be some medicines I cannot take with my hepatitis C medicines.	
5. I understand that Medicaid may only pay for hepatitis C medicines for a certain number weeks over my lifetime.	
6. I understand that past use of certain hepatitis C medicines may keep me from using medicines like them again.	
7. I am not currently using IV drugs or abusing alcohol.	
8. I will not use IV drugs or abuse alcohol (which could seriously damage my liver) while on treatment or after completion of treatment.	
9. I am (OR my female partner is) not pregnant.	
10. I am (OR my female partner is) not planning on getting pregnant while I am on my hepatitis C medicines and for at least 6 months after I finish them.	
11. I (OR my female partner) will use two forms of non-hormonal birth control while I am taking my hepatitis C medicines and for at least 6 months after I finish taking them.	
12. I (OR my female partner) will have monthly pregnancy testing while I am taking my hepatitis C medicines.	

I have read the above statements and understand the agreement.

Patient Signature: _____

Date: _____

Physician Signature: _____

Date: _____