OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692 No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

Hepatitis-C Antiviral Drugs (Non-Preferred)

DRUG REQUESTED: ***Check applicable box below for requested Hepatitis-C therapy:***			
❑ **Daklinza™**	❑ **Epclusa®**	❑ **Harvoni®**	❑ **Olysio™**
❑ **Sovaldi®**	❑ **Technivie™**	❑ **Viekira Pak™**	❑ **Viekira XR™**
❑ **Vosevi®**	❑ **Zepatier®**	❑ **peginterferon alfa**	❑ **ribavirin**

- **Patient tried and failed *PREFERRED* drug (Mavyret™)**

DRUG INFORMATION: ***Complete information below. Authorization process will be delayed if incomplete.***

Drug Name: _____

Drug Form: _____ **Strength**: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Quantity per Day: _____ ***ICD Code, if applicable*:** _____

CLINICAL CRITERIA*: *Check ALL boxes below to qualify. ALL pertinent chart notes and lab values MUST be included in this request or authorization process will be delayed.

- **Treatment is being prescribed by *(check applicable box below)*:**

❑ **Gastroenterologist**	❑ **Hepatologist**	❑ **ID Specialist**
❑ **Transplant Specialist**	❑ **Infectious Disease**	❑ **Other**: _____

DIAGNOSIS:+

❑ **Chronic Hepatitis C**	❑ **Compensated cirrhosis**	❑ **Hepatocellular carcinoma**
❑ **Status post-liver transplant**	❑ **Decompensated cirrhosis (Child-Pugh score class B or C)**	

HCV Genotype: ❑ **1a** (polymorphism) ❑ **Yes** ❑ **No** ❑ **N/A** (***If yes, submit test results***) ❑ **1b** ❑ **2** ❑ **3** ❑ **4** ❑ **5** ❑ **6**

Choose One: ❑ Treatment initiation ❑ Continuation of therapy, current week: _____

ADHERANCE:

Prescriber has assessed the member for adherence with medical and pharmacological treatment. ❑ Yes ❑ No

Prescriber has reviewed Hepatitis C Patient Treatment Agreement with the member. Signed agreement attached. ❑ Yes ❑ No

***SUBSTANCE USE DISORDER SCREENING*:**

Prescriber has evaluated the member for current substance use disorder including alcohol use disorder. ❑ Yes ❑ No

- Members identified with a substance use disorder should be referred for treatment.
- **Member CANNOT be denied Hepatitis C treatment for sole reason of substance use.**
- Testing for illicit drug and/or alcohol use is **not** required.
- A map with Medicaid Addiction and Recovery Treatment providers can be found at http://www.dmas.virginia.gov/Content_Pgs/bh-home.aspx.

OTHER CO-MORBID CONDITION(S):

Decompensated cirrhosis (Child-Pugh score greater than 6 [class B or C]) ❑ Yes ❑ No

Hx severe renal impairment (eGFR <30 mL/min/1.73m^2) or end stage renal disease requiring hemodialysis ❑ Yes ❑ No

If yes to any, please give details: _____

_____

(continued on next page)

LAB VALUES:

Original Baseline	HCV RNA value:		Date Drawn:	
Current Baseline	HCV RNA value:		Date Drawn:	
	(Within past 4 weeks)			
Tx Week 4	HCV RNA value:		Date Drawn:	
Tx Week Other	HCV RNA value:		Date Drawn:	

If HCV RNA is detectable at week 4 of treatment, repeat quantitative HCV RNA viral load testing is recommended after 2 additional weeks of treatment (treatment week 6). If quantitative HCV viral load has increased by greater than 10-fold (>1 log10 IU/mL) on repeat testing at week 6 (or thereafter), then discontinuation of HCV treatment is recommended.

***PREVIOUS* HEPATITIS C TREATMENTS**
Treatment Experienced with (check below ALL that apply):

❑ Daklinza™ (daclatasvir)	❑ Epclusa® (sofosbuvir/velpatasvir)	❑ Harvoni® (ledipasvir-sofosbuvir)	❑ Incivek® (telaprevir)
❑ Olysio™(simeprevir)	❑ Interferon	❑ Olysio™ (simeprevir)	❑ peginterferon
❑ ribavirin	❑ Sovaldi® (sofosbuvir)	❑ Technivie™ (ombitasvir/paritaprevir/ritonavir)	❑ Viekira XR™ (ombitasvir/paritaprevir/ritonavir, dasabuvir)
❑ Viekira Pak™ (ombitasvir/paritaprevir/ritonavir) with dasabuvir	❑ Vosevi® (sofosbuvir, velpatasvir & voxilaprevir)	❑ Zepatier® (elbasvir and grazoprevir)	

Document dates received: _____

I attest that all information provided is accurate. ❑ Yes ❑ No

_____ _____

(By signing, the Physician confirms the above information is accurate and verifiable by patient records.) ***(Date)***

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***REVISED/UPDATED: 7/1/2018**

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: _____