

# 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.

**Drug Requested:** Mavyret™ (glecaprevir/piprentasvir) (**PREFERRED**)

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

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.

- Is patient ≥ 18 years of age?  Yes  No

**DIAGNOSIS:** Check box below that applies. If incomplete, authorization process might be delayed.

<input type="checkbox"/> Chronic Hepatitis C	<input type="checkbox"/> Compensated cirrhosis	<input type="checkbox"/> Hepatocellular carcinoma
<input type="checkbox"/> Status post-liver transplant	<input type="checkbox"/> Decompensated cirrhosis (Child Pugh score class B or C)	

**HCV Genotype:** Check box below that applies.

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
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**Choose One:**  treatment naïve  treatment experienced

**Duration of Authorization:**  8 weeks  12 weeks  16 weeks

**ADHERENCE:** Boxes **MUST** be checked or authorization process might be delayed.

1. Prescriber has assessed the patient for adherence with medical and drug treatment?  Yes  No
2. Prescriber has reviewed the *Hepatitis C Patient Treatment Agreement* with the patient?  Yes  No
3. Signed [Hepatitis C Patient Treatment Agreement Form](#) (located on the Virginia Medicaid Pharmacy Services Web Portal) is attached.  Yes  No

**SUBSTANCE USE DISORDER (SUD) AND CO-MORBID DISEASE SCREENING:**

1. Prescriber has evaluated the patient for current SUD including alcohol use disorder?  Yes  No
  - Patients identified with a substance use disorder should be referred for treatment.
  - **Patient 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/Coontent\\_Pgs/bh-home.aspx](http://www.dmas.virginia.gov/Coontent_Pgs/bh-home.aspx)
2. Prescriber has evaluated patient for the Hepatitis B virus **and** HIV?  Yes  No
3. Patient tested positive for Hepatitis B or HIV?  Yes  No
  - Patients identified with Hepatitis B or HIV should be referred to a hepatologist, infectious disease specialist, or gastroenterologist for treatment.
4. Patient is taking atazanavir (Reyataz®) or rifampin?  Yes  No

(signature on next page. Hep-C Treatment Agreement on Page 3.)

I attest that all information provided is accurate:

Yes     No

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

\_\_\_\_\_  
(Prescriber Signature Required)

\_\_\_\_\_  
(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.

<b>Patient Information</b>	<b>Prescriber Information</b>
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:** \_\_\_\_\_