OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

Hepatitis C Therapy Member Treatment Agreement

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. **If information provided is NOT complete, correct, or legible, authorization will be delayed.**

HEPATITIS-C MEDICATION REGIMEN: Complete **all** information below or authorization will be delayed. **Signature must be included with request form.**

Drug Name/Form: _____

Strength: _____ **Quantity per Day**: _____

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

Weight in Kilograms: _____ **Kg** **Gender:** ❑ Male ❑ Female

==========

Member Information:

Member 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.

Full Name: _____

Member Optima #: _____ **Date of Birth**: _____

==========

Prescriber Information:

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

Name: _____

Office Contact Name: _____ **Date:** _____

Phone Number: _____ **Fax Number**: _____

DEA OR NPI #: _____

(Continued on next page)

Diagnosis and Medical Information

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.

_____ _____

Member Signature **(Required)** Date

_____ _____

Prescriber Signature **(Required)** Date

(By signing, physician confirms the above information is accurate and verifiable by member records.)

REVISED/UPDATED: ~~11/17/2016; 6/19/2017; 10/11/2017; 8/13/2018;~~ **5/25/2019**

;