

**OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)**

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:			
<input type="checkbox"/> Daklinza™	<input type="checkbox"/> Epclusa®	<input type="checkbox"/> Harvoni®	<input type="checkbox"/> Olysio™
<input type="checkbox"/> Sovaldi®	<input type="checkbox"/> Technivie™	<input type="checkbox"/> Viekira Pak™	<input type="checkbox"/> Viekira XR™
<input type="checkbox"/> Vosevi®	<input type="checkbox"/> Zepatier®	<input type="checkbox"/> peginterferon alfa	<input type="checkbox"/> ribavirin

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

DRUG INFORMATION: Complete information below or authorization will be delayed.

Drug Name: _____

Drug Form: _____ Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

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

CLINICAL CRITERIA: Check <u>ALL</u> boxes below to qualify. <u>ALL</u> pertinent chart notes and lab values <u>MUST</u> be included in this request to ensure authorization will <u>NOT</u> be delayed.
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- Treatment is being prescribed by (check applicable box below):

<input type="checkbox"/> Gastroenterologist	<input type="checkbox"/> Hepatologist	<input type="checkbox"/> ID Specialist
<input type="checkbox"/> Transplant Specialist	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Other: _____

DIAGNOSIS:+		
<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: 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

(continued on next page)

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/1.73m²) or end stage renal disease requiring hemodialysis Yes No

If yes to any, please give details: _____

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):

<input type="checkbox"/> Daklinza [™] (daclatasvir)	<input type="checkbox"/> Epclusa [®] (sofosbuvir/velpatasvir)	<input type="checkbox"/> Harvoni [®] (ledipasvir- sofosbuvir)	<input type="checkbox"/> Incivek [®] (telaprevir)
<input type="checkbox"/> Olysio [™] (simeprevir)	<input type="checkbox"/> Interferon	<input type="checkbox"/> peginterferon	<input type="checkbox"/> ribavirin
<input type="checkbox"/> Sovaldi [®] (sofosbuvir)	<input type="checkbox"/> Technivie [™] (ombitasvir/paritapre vir/ritonavir)	<input type="checkbox"/> Viekira XR [™] (ombitasvir/paritaprevir/ ritonavir, dasabuvir)	<input type="checkbox"/> Viekira Pak [™] (ombitasvir/paritapre vir/ritonavir) with dasabuvir
<input type="checkbox"/> Vosevi [®] (sofosbuvir, velpatasvir & voxilaprevir)	<input type="checkbox"/> Zepatier [®] (elbasvir and grazoprevir)	<input type="checkbox"/>	

(Continued on next page; signature page **must** be attached to request.)

(Signature page **must** be included with request.)

Document dates received: _____

I attest that all information provided is accurate.

Yes No

(Date)

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

****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 #: _____

*Approved by Pharmacy and Therapeutics Committee: 10/19/2017

REVISED/UPDATED: 6/25/2017; 8/30/2017; 12/30/2017; 1/29/2018; 6/15/2018; 8/22/2018

**Optima Health Community Care
AND
Optima Family Care
(Medicaid)**

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: _____

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|---|
| 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. |

(Continued on next page; Signature **MUST** be included with this request.)

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| 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:** _____