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

Hepatitis-C Antiviral Drugs (Non-Preferred)

DRUG REQUESTED: Check below the requested Hepatitis-C therapy that applies:			
❑ **Pegasys® Proclick /syringe/kit/vial**	❑ **Epclusa®**	❑ **Sovaldi®**	❑ **Vosevi®**
❑ **Technivie™**	❑ **Viekira Pak™**	❑ **Viekira XR™**	❑ **Zepatier®**
❑ **Harvoni®**	❑ **ledipasvir/sofosbuvir** (generic Harvoni®)	❑	

- **Patient tried and failed PREFERRED drug (Mavyret™ AND sofosbuvir/velpatasvir)**

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

Drug Name: _____

Drug Form: _____ **Strength**: _____

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

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

Member Age: _____

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation, including lab results and/or chart notes **(when required)**, **must** be provided or request will be denied.

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

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

DIAGNOSIS: Check box below that applies to ensure authorization will **NOT** be delayed.		
❑ **Chronic Hepatitis C**	❑ **Compensated cirrhosis**	❑ **Hepatocellular carcinoma**
❑ **Status post-liver transplant**	❑ **Decompensated cirrhosis (Child-Pugh score class B or C)**	

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HCV Genotype: Check box below that applies. **(If YES is checked, test results MUST be submitted.)**				
❑ **1a** (polymorphism)	❑ **1a** with polymorphism	❑ **Yes (Submit test results)**	❑ **No**	❑ **N/A**
❑ **1b**	❑ **2**	❑ **3**	❑ **4**	
❑ **5**	❑ **6**			

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

ADHERANCE:

1. Has prescriber assessed member for adherence with medical and pharmacological treatment? ❑ Yes ❑ No
2. Has prescriber reviewed the Hepatitis C Member Treatment Agreement with the member? **(Attach the signed Hepatitis Member Treatment Agreement form located on the Optima Health website** www.optimahealth.com) ❑ Yes ❑ No

SUBSTANCE USE DISORDER SCREENING:

1. Has prescriber evaluated 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.

OTHER CO-MORBID CONDITION(S):

1. Decompensated cirrhosis (Child-Pugh score greater than 6 [class B or C])? ❑ Yes ❑ No
2. Hx severe renal impairment (eGFR <30 mL/min/1.73m^2) or end stage renal disease requiring hemodialysis ❑ Yes ❑ No

   If **YES** to any, provide details: _____

_____

_____

LAB VALUES:

1. **Original Baseline:** _____ HCV RNA value: _____ Date Drawn: _____
2. **Current Baseline:** _____ HCV RNA value: _____ Date Drawn: _____
   (Within past 4 weeks)
3. **Tx Week 4:** _____ HCV RNA value: _____ Date Drawn: _____
4. **Tx Week Other:** _____ HCV RNA value: _____ Date Drawn: _____

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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):			
❑ Epclusa® (sofosbuvir/velpatasvir)	❑ Sovaldi® (sofosbuvir)	❑ Harvoni® (ledipasvir-sofosbuvir)	❑ Incivek® (telaprevir) **(discontinued in 2014)**
❑ interferon	❑ ledipasvir-sofosbuvir	❑ Olysio™ (simeprevir) **(will be discontinued in June 2019)**	❑ peginterferon
❑ ribavirin	❑ Harvoni® (ledipasvir-sofosbuvir)	❑ sofosbuvir/ velpatasvir	❑ Technivie™ (ombitasvir/paritaprevir /ritonavir)
❑ Viekira XR™ (ombitasvir/paritaprevir /ritonavir, dasabuvir)	❑ Viekira Pak™ (ombitasvir/paritaprevir/ ritonavir) with dasabuvir	❑ Zepatier® (elbasvir and grazoprevir)	❑ Vosevi® (sofosbuvir, velpatasvir & voxilaprevir)

Document dates received: _____

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

_____ _____

(Physician's signature) (Date)

(By signing, the Physician confirms the above information is accurate and verifiable by member 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;~~ **5/24/2019**