# 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**.

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

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

**Drug Form/Strength:** _____

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

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

**CLINICAL CRITERIA**: Check **ALL** boxes below to qualify to ensure authorization will **NOT** be delayed. **ALL** pertinent chart notes and lab values **MUST** be included in this request.

- **Is patient ≥ 18 years of age?** ❑ Yes ❑ No

**DIAGNOSIS:** Check box 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)** | |

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

| | | | | | |
|---|---|---|---|---|---|
| ❑ **1** | ❑ **2** | ❑ **3** | ❑ **4** | ❑ **5** | ❑ **6** |

**Choose One**: ❑ treatment naïve ❑ treatment experienced

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

**ADHERENCE**: Boxes **MUST** be checked to ensure authorization will **NOT** 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.

(Continued on next page)

- **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/Content_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

**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:** ~~12/27/2017; 6/15/2018;~~ **8/27/2018**

***(Hepatitis-C Patient Therapy Treatment Agreement MUST be signed and attached to request.)***

# 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: _____ |

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.

***(Continued on next page; Hepatitis-C Therapy Patient Treatment Agreement MUST be signed and attached to request.)***

***(Hepatitis-C Therapy Patient Treatment Agreement MUST be signed and included to request.)***

**I have read the above statements and understand the agreement.**

**Patient Signature: _____ Date: _____**

**Physician Signature: _____ Date: _____**