

OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003 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

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

Drug Name: _____

Drug Form/Strength: _____ Quantity per Day: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ 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. Check applicable box(es) below for **previous** Hepatitis-C treatments/therapy:

- 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

Prescribed has reviewed Hepatitis C Patient Treatment Agreement with the member. Signed agreement attached. Yes No

SUBSTANCE USE DISORDER SCREENING

Prescriber has evaluated the member for current substance use disorder including alcohol use disorder.

- 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.** Yes No
- Testing for illicit drug and/or alcohol use is **not** required.

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: _____

(continued on next page)

LAB VALUES

Original Baseline	HCV RNA value: _____	Date Drawn: _____
Current Baseline	HCV RNA value: _____	Date Drawn: _____
<i>(Within past 4 weeks)</i>		
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™	<input type="checkbox"/> Epclusa®	<input type="checkbox"/> Harvoni®	<input type="checkbox"/> Incivek®
<input type="checkbox"/> Olysio™	<input type="checkbox"/> Sovaldi®	<input type="checkbox"/> Technivie™	<input type="checkbox"/> Victrelis®
<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		

Document dates received: _____

****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: _____

Prescriber Signature: _____ Date: _____

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;

Optima Health Community Care

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.	

I have read the above statements and understand the agreement.

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____