

# 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)

<b>DRUG REQUESTED:</b> 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. Authorization process will be delayed if incomplete.

Drug Name: \_\_\_\_\_  
 Drug Form: \_\_\_\_\_ Strength: \_\_\_\_\_  
 Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_  
 Quantity per Day: \_\_\_\_\_ 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.

- 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

#### 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](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/1.73m<sup>2</sup>) or end stage renal disease requiring hemodialysis  Yes  No  
 If yes to any, please give details: \_\_\_\_\_

(continued on next page)

**LAB VALUES:**

<b>Original Baseline</b>	HCV RNA value: _____	Date Drawn: _____
<b>Current Baseline</b>	HCV RNA value: _____	Date Drawn: _____
<i>(Within past 4 weeks)</i>		
<b>Tx Week 4</b>	HCV RNA value: _____	Date Drawn: _____
<b>Tx Week Other</b>	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"/> Olysio™ (simeprevir)	<input type="checkbox"/> peginterferon
<input type="checkbox"/> ribavirin	<input type="checkbox"/> Sovaldi® (sofosbuvir)	<input type="checkbox"/> Technivie™ (ombitasvir/paritaprevir/ritonavir)	<input type="checkbox"/> Viekira XR™ (ombitasvir/paritaprevir/ritonavir, dasabuvir)
<input type="checkbox"/> Viekira Pak™ (ombitasvir/paritaprevir/ritonavir) with dasabuvir	<input type="checkbox"/> Vosevi® (sofosbuvir, velpatasvir & voxilaprevir)	<input type="checkbox"/> Zepatier® (elbasvir and grazoprevir)	

**Document dates received:** \_\_\_\_\_

*I attest that all information provided is accurate.*

Yes  No

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

(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 #: \_\_\_\_\_

\*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.

# 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:** \_\_\_\_\_