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 forms will delay the process. All questions must be answered.***

Drug Requested: **HEPATITIS-C ANTIVIRALS** ***MEDICAID***

Treatment is being prescribed by or in consultation with:

❑ **Gastroenterologist** ❑ **Hepatologist** ❑ **ID Specialist** ❑ **Transplant Specialist** ❑ **Other:** _____

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Name/Form: _____ **Strength:** _____

Dosing Schedule/Quantity per Day: _____ **Length of Therapy:** _____

Diagnosis: _____ ***ICD CODE, if applicable:*** _____

CLINICAL CRITERIA: Check applicable boxes below in each section. If not met, authorization process will be delayed.

DIAGNOSIS

❑ Chronic Hepatitis C ❑ Compensated cirrhosis ❑Decompensated cirrhosis (Child-Pugh score class B or C)

❑ Hepatocellular carcinoma ❑ Status post-liver transplant

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

The 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/1.73m^2) 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.

(continued on next page)

PREVIOUS HEPATITIS C TREATMENTS

❑ Treatment Experienced **with (check *ALL* that apply)**	❑ Treatment naïve	❑ Daklinza™ (daclatasvir)
❑ Epclusa® (sofosbuvir/velpatasvir	❑ Harvoni® (ledipasvir-sofosbuvir)	❑ Incivek® (telaprevir)
❑ Interferon	❑ Olysio™ (simeprevir)	❑ Peginterferon
❑ ribavirin	❑ Sovaldi® (sofosbuvir)	❑ Technivie® (ombitasvir/paritaprevir/ritonavir)
❑ Zepatier™ (elbasvir and grazoprevir)	❑ Viekira Pak™ (ombitasvir/paritaprevir/ritonavir) with dasabuvir	❑ Viekira XR (ombitasvir/ paritaprevir/ritonavir; dasabuvir)

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 #: _____

REVISED/UPDATED: ~~6/25/2017;~~ **8/30/2017**

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: _____