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.***

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

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

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.

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

DIAGNOSIS: ***Check box below that applies. If incomplete, authorization process might 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 or authorization process might 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.
   - **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/Coontent_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

(signature on next page. Hep-C Treatment Agreement on Page 3.)

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**

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: _____