OPTIMA HEALTH PLAN

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**.

Hepatitis-C Antiviral Drugs

(Non-Preferred) (FAMIS Only)

DRUG REQUESTED – check the applicable box below for Hepatitis-C therapy:			
❑ **Daklinza™**	❑ **Epclusa®**	❑ **Harvoni®**	❑ **Olysio™**
❑ **Sovaldi®**	❑ **Technivie™**	❑ **Viekira Pak™**	❑ **Viekira XR™**
❑ **Vosevi®**	❑ **Zepatier®**	❑ **peginterferon alfa**	❑ **ribavirin**
❑ **sofosbuvir (400mg)/ velpatasvir (100mg)**	❑ **ledipasvir (90mg)/ sofosbuvir (400mg)**		

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

Drug Name: _____

Drug Form/Strength: _____ **Quantity per Day**: _____

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

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

- **Optima Health coverage criteria for the new direct-acting agents are based on careful consideration of the evidence-based guidance of professional specialty societies, published guidelines, and physician subject matter experts specialists.**
- **ONE TIME APPROVAL FOR ANY and ALL DIRECT-ACTING ANTIVIRAL (DAA) PER LIFETIME (EXCEPTION)**

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:

❑ Daklinza™	❑ Epclusa®	❑ Harvoni®	❑ Incivek®
❑ Olysio™	❑ Sovaldi®	❑ Technivie™	❑ Victrelis®
❑ Viekira Pak™	❑ Viekira XR™	❑ Vosevi®	❑ Zepatier®
❑ peginterferon alfa	❑ ribavirin	❑ Mavyret™	
❑ **sofosbuvir (400mg)/ velpatasvir (100mg)**	❑ **ledipasvir (90mg)/ sofosbuvir (400mg)**		

- **Treatment is being prescribed by (check box below that applies):**

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

- **Patient is:** ❑ treatment naïve ❑ relapse ❑ treatment experienced
- **Patient tried and failed PREFERRED drug (Mavyret™)**
- Patient has a diagnosis of chronic HCV genotype. ❑ **1** ❑ **2** ❑ **3** ❑ **4** ❑ **5** ❑ **6** **(Labs must be included)**
- A documented viral load (HCV RNA) taken within 6 months of beginning therapy **(Include labs)**
- Is member co-infected with hepatitis B **(send labs)** ❑ Yes ❑ No

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- Is member co-infected with HIV-1? ❑ Yes ❑ No
- Has patient ever been successfully treated for chronic HCV? ❑ Yes ❑ No
- Does patient have hepatocellular carcinoma or severe cirrhosis awaiting a liver transplant? ❑ Yes ❑ No
- Does patient have compensated cirrhosis? **(Include labs)** ❑ Yes ❑ No
- Does patient has decompensated cirrhosis (which is defined as a Child-Pugh score greater than 6 [class B or C])? **(Include labs)** ❑ Yes ❑ No

For assessment of disease severity, please refer to the table below for a Fibrosis/stage score:

Metavir	Scheuer/Batts, Ludwig/Tsui Stage	Ishak, et al: Fibrosis Scoring	Knodell et al: Fibrosis Scoring
F0=no fibrosis	0=No fibrosis, normal amount of connective tissue	0=No fibrosis	0=No fibrosis
F1=portal fibrosis without septa	1=Portal/periportal fibrosis	1=Expansion of some portal areas with or without septa	1=Fibrous some portal expansion with or without septa
F2=portal fibrosis with rare septa	2=Septal fibrosis	2=Expansion of most portal areas with or without septa	2= Fibrous most portal expansion with or without septa
F3=numerous septa, not cirrhosis	3=Bridging fibrosis with architectural distortion.	3=Expansion of most portal areas with occasional portal to portal bridging	3=Bridging Fibrosis
F4=cirrhosis	4=Cirrhosis, probable cirrhosis	4=Expansion of portal areas with marked bridging (portal-portal and/or portal-central)	4=Cirrhosis
		5=Marked bridging with occasional nodules (incomplete cirrhosis)	
		6=Cirrhosis, probable or definitive	

Cirrhosis requires 2 liver assessments with Lab values & symptoms correlating with Cirrhosis. Submit a Liver assessment documenting fibrosis including one (1) of the following: (Please Note: Contra-Indication to a liver assessment would lead to an incomplete form.)

❑ **Liver biopsy confirming**:

❑ METAVIR score	❑ Knodell fibrosis score (last #-reported separately)
❑ Ishak stage	❑ Batts-Ludwig stage

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- ❑ Transient elastography (FibroScan) score of: _____ kPa
- ❑ FibroTest (FibroSure) score of: _____ **(Alcohol test MUST be same date of FibroTest)**
- ❑ Shear wave elastography (ElastPQ) score of: _____ m/s
- ❑ Shear wave (SWE supersonic tech) score of: _____ m/s
- ❑ Shear wave (VTTQ) Siemens score of: _____ m/s
- ❑ **LABS need to be submitted with this request form for the following:** ❑ **CBC** ❑ **BMP**

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: ~~12/30/2017~~ **1/7/2019**

Optima Health Plan

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, OPTIMA 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 OPTIMA 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:** _____