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.**

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

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

Drug Form/Strength: _____

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 to ensure authorization will **NOT** be delayed**.**

- **Treatment is being prescribed by**: ❑ **Gastroenterologist** ❑ **Hepatologist** ❑ **ID Specialist**

  Patient is: ❑ **treatment naïve** ❑ **relapse** ❑ **treatment experienced**

- Please indicate **PREVIOUS Hep-C therapy/treatment (check all that apply)**:

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

- Patient has a diagnosis of chronic HCV genotype. ❑ **1** ❑ **2** ❑ **3** ❑ **4** ❑ **5** ❑ **6** **(Labs must be included)**
- **Patient tried and failed PREFERRED drug Mavyret™**
- 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
- Is member co-infected with HIV-1? ❑ Yes ❑ No
- Has the patient ever been successfully treated for chronic HCV? ❑ Yes ❑ No
- Does the patient have hepatocellular carcinoma or severe cirrhosis awaiting a liver transplant? ❑ Yes ❑ No
- Does the patient have compensated cirrhosis? **(include labs)** ❑ Yes ❑ No
- Does the patient has decompensated cirrhosis (which is defined as a Child-Pugh score greater than 6 [class B or C])? **(include labs)** ❑ Yes ❑ No

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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. Liver assessment MUST be submitted to determine length of therapy. One of the following liver assessments MUST be submitted. (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

- ❑ Transient elastography (FibroScan) of: _____ kPa
- ❑ FibroTest (FibroSure) score of: _____ **(Alcohol test MUST be same date as 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**

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Treatment Naïve Patients:

HCV Genotype	Treatment Duration	
	No Cirrhosis	**Compensated Cirrhosis (Child-Pugh A)**
1, 2, 3, 4, 5, or 6	8 weeks	12 weeks

Treatment Experienced Patients

		Treatment Duration	
HCV Genotype	**Patients Previously Treated With a Regimen Containing:**	**No Cirrhosis**	**Compensated Cirrhosis (Child-Pugh A)**
1	An NS5A inhibitor[1] without prior treatment with an NS3/4A protease inhibitor	16 weeks	16 weeks
	An NS3/4A PI[2] without prior treatment with an NS5A inhibitor	12 weeks	12 weeks
1, 2, 4, 5, or 6	PRS[3]	8 weeks	12 weeks
3	PRS[3]	16 weeks	16 weeks

1. In clinical trials, subjects were treated with prior regimens containing ledipasvir and sofosbuvir or daclatasvir with pegylated interferon and ribavirin.
2. In clinical trials, subjects were treated with prior regimens containing simeprevir and sofosbuvir, or simeprevir, boceprevir, or telaprevir with pegylated interferon and ribavirin.
3. PRS=Prior treatment experience with regimens containing interferon, pegylated interferon, ribavirin, and/or sofosbuvir, but no prior treatment experience with an HCV NS3/4A PI or NS5A inhibitor.

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:** 10/1/2017
REVISED/UPDATED: ~~10/5/2017; 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, 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:** _____