

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:

<input type="checkbox"/> METAVIR score	<input type="checkbox"/> Knodell fibrosis score (last #-reported separately)
<input type="checkbox"/> Ishak stage	<input type="checkbox"/> Batts-Ludwig stage

- Transient elastography (FibroScan) 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

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

HCV Genotype	Patients Previously Treated With a Regimen Containing:	Treatment Duration	
		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

- In clinical trials, subjects were treated with prior regimens containing ledipasvir and sofosbuvir or daclatasvir with pegylated interferon and ribavirin.
- In clinical trials, subjects were treated with prior regimens containing simeprevir and sofosbuvir, or simeprevir, boceprevir, or telaprevir with pegylated interferon and ribavirin.
- 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 #: _____

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:** _____