MedStar Family Choice

Caring For You. Caring About You.

MedStar Health

Fax completed form to MSFC DC 202 243-5496
Medication to be supplied by Caremark Specialty Pharmacy after approval

HEPATITIS C THERAPY PRIOR-AUTHORIZATION FORM and PRESCRIPTION

Incomplete form will be returned

Please attach copies of the member's medical history summary, lab and genetic test reports

****Please review our clinical criteria before submitting this form****

Member Information

Member:_____ Date of Birth:_____/_____/_____

MA#: _____ MSFC # _____ Body Weight:_____ kg

Current Home Address:_____

_____

Current Phone #: ( ) _____ - _____

Diagnosis (Attach genotype test results)

□ Acute Hep C □ Chronic Hep C □ Hepatocellular Carcinoma other:_____

If s/p TRANSPLANT,
□ Genotype of pre-transplant liver: _____
□ Genotype of post-transplant liver: _____

What is member's HCV genotype (including subtype)?_____

Has a liver biopsy been performed? □Yes □ No Test date : _____/_____/_____

Provide a copy of biopsy results or other fibrosis test (e.g., FibroSure, HepaScore, et.al) ,
Specify Metavir grade:_____ stage:_____

Hepatitis C Member Characteristics

This request is for: □ New Therapy □ Relapser □ Partial Responder □ Non-Responder

□ Compensated cirrhosis (treatment naïve or experienced) □ No cirrhosis □ Decompensated liver Ds

Drug Regimen with Strengths/Dosages/Length of Therapy and Treatment Plan

Sovaldi®:_____ Olysio™:_____

Pegylated interferon: _____ Ribavirin:_____

Other: _____

Anticipated total treatment duration: _____

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(Adherence with prescribed therapy is a condition for payment for continuation therapy for up to the allowed timeframe for each HCV genotype. The recipient's Medicaid drug history will be reviewed prior to approval.)

Has drug therapy treatment plan been developed and discussed with member ☐ Yes ☐ No
Any issues with drug adherence? ☐ Yes ☐ No Explain:_____
Adherence assessment:_____

Laboratory Results

If prescribing Olysio™, Q80K polymorphism testing:

Test date: _____/_____/_____ Result:_____

Baseline HCV RNA level (within 30 day pre-treatment): _____ log10_____ Date:_____/_____/_____

Liver enzyme levels: Baseline ALT/AST:_____ Date measured:_____/_____/_____

Baseline platelet:_____ Date measured:_____/_____/_____

Baseline hemoglobin/hematocrit:_____ Date measured:_____/_____/_____

Negative Drug Test (within 90 days of authorization): ☐ Yes Date measured:_____/_____/_____

Medical History

Does member have HIV/HCV co-infection? ☐Yes ☐ No

Has the member had a solid organ transplant? ☐ Yes ☐ No Specify transplant date:_____/_____/_____

Does the member have a history of any of the following: ☐ No to all
☐ anemia ☐ autoimmune hepatitis or other autoimmune conditions ☐ pregnant ☐ renal d/s ☐ thrombocytopenia
☐ severe concurrent medical d/s (i.e. AIDS, cancer, significant CAD) ☐ hemoglobinopathies (i.e. sickle cell, thalassemia)
☐ currently on didanosine ☐ unstable CVD

Does the member have history of depression or mood disorder? ☐ Yes ☐ No
If yes, is the member stable on current medication? ☐Yes ☐ No

Does the member have history of Drug/Alcohol Abuse? ☐Yes ☐ No If yes, is abstinent for last 3 months? ☐Yes ☐ No

Prior Drug Utilization

List concomitant drugs that might interact with any of the prescribed Hep C drugs:_____
_____

List all previous hepatitis C therapies including adverse effects associated with prior therapy and reason for drug failure. If the member is contraindicated or ineligible to receive a portion of a therapy (interferon), please provide a reason:_____
_____
_____

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If the member's MSFC and/or Medicaid eligibility changes during therapy and the member is no longer eligible for Medicaid prescription drug assistance, is the physician prepared to enroll the member in other patient assistant drug programs to complete therapy? ☐**Yes** ☐ **No**

Prescriber's Information and Attestation

I certify that the information provided is accurate. Supporting documentation is available for State audits.

_____ Prescriber's Name: _____ Date: _____/____ /____
(Prescriber's signature)

Practice Specialty: _____ NPI:_____ DEA: _____

Telephone# (_____) – _____- _____ Fax# (_____) - _____ - _____

Address: _____

_____

- Medications will be dispensed through Caremark Specialty Pharmacy
- Initial authorizations will be for 8 weeks
- HCV RNA Level at Treatment week 4 will be **REQUIRED** for continued authorization after 8 weeks. Additional testing at 12 weeks may also be required when clinically appropriate.
- A copy of the **HEPATITIS C THERAPY CONTINUATION AUTHORIZATION FORM and PRESCRIPTION** will be sent to the prescriber's fax number provided above prior to the renewal date as a reminder