Hepatitis C Medication Coverage Request

Prescriber: To avoid review delays, make sure all sections of both pages are completed. ***Questions?*** Call 1.800.492.7259.

FAX to: 1.888.883.5434

Member Name: Member ID: Date of Birth:

1. Please submit medical chart documentation of the following:
   a. Evidence of liver disease progression and/or other extra-hepatic disease due to HCV infection.
   b. Prescribed hepatitis treatment regimen, historical treatment regimens and outcome, and all known concurrent drug therapy.
   c. Pertinent social history describing use of alcohol or illicit drugs. If any use has occurred within the past year, please include a negative urine or blood screen within one month prior to treatment start date.

2. What is the patient's HCV genotype? _____

3. What is the patient's most recent HCV RNA level? (baseline for treatment) _____IU/mL _____date

4. Please list any HCV treatment regimens used previously:

Regimen	Dates	Response

5. Proposed start date: _____

6. Complete the following attestations:

I have evaluated and counseled the patient and determined the following to be true.

The patient is:

a. aware of the high cost of this medication; and
b. prepared to adhere to the medication instructions, and understands the importance of adherence; and
c. willing and able to attend all necessary follow-up provider appointments and lab appointments; and
d. willing to participate in any health plan initiated outreach to ensure optimal outcomes; and
e. unlikely to require hospitalization for any type of elective procedure during the prescribed duration of therapy; and
f. at low risk for HCV reinfection.

Provider Signature _____ Date _____

Last update: November 18, 2014

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Member Name: Member ID: Date of Birth:

I understand that I am being prescribed treatment for chronic hepatitis viral infection. Because of the cost associated with this therapy and the need to take it as my provider has prescribed to achieve the best results, I confirm the following statements are true:

1. I am aware that Harvoni® and Sovaldi® are priced at just over and Olysio® just under $1,000 for each day of treatment.
2. I have received counseling and am prepared to take this medication as instructed.
3. I will attend all necessary follow-up provider and lab appointments.
4. I will participate in any health plan initiated outreach to ensure optimal outcomes.
5. I agree to abstain from alcohol and all illegal and recreational drugs while on the treatment regimen and will provide urine or blood specimens at the doctor's request to monitor my compliance.
6. I am motivated to achieve a cure for my Hepatitis C and to refrain from behaviors that might lead to reinfection.
7. I understand that lost or stolen medications will not be replaced.
8. I agree to inform both my provider and pharmacy within one business day if I stop taking my medication as directed or am hospitalized for any reason during the course of my treatment.

I have provided three contact numbers in case I need to be contacted during the course of my treatment: (contact name/relationship/number)

1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____

I have identified any over-the-counter medications or herbal supplements I might take during the course of my hepatitis treatment. (Due to the high potential for drug interactions which can reduce the effectiveness of treatment, a pharmacist will evaluate your medications to ensure that no drug-drug interactions occur.)

_____

_____

Member Signature _____ Date _____