**Physician Request Form for Hepatitis C Therapies**
Fax to PerformRx at 855-811-9332, or call 888-602-3741
To speak to a representative. ***All pages of this form must be completed for processing.***

AmeriHealth Caritas District of Columbia

Patient Name: _____ Patient ID: _____
Patient Address: _____ Date of Birth: _____
City: _____ State: _____ Zip: _____ Weight: _____
Prescriber Name: _____ NPI: _____
Prescriber Address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Fax: _____
Contact Name: _____
Prescriber Specialty: ☐Hepatology ☐Gastroenterology ☐Infectious Disease ☐Transplant ☐HIV
Requested Regimen, Dose and Duration: _____

**Patient MUST be enrolled in the health plan's Hepatitis C Adherence Program for approval.**

- Patient is enrolled? ☐Yes ☐No *To enroll patient, call Voice Line: 800-486-1991 or TDD/TTY: 866-533-5495*

**Provider attests to all of the following:**

- Member has a limited life expectancy due to non-liver related comorbid condition (less than 12 months): ☐Yes ☐No
- Member has been screened for hepatitis B (HBV) and human immunodeficiency virus (HIV): ☐Yes ☐No
  Patient is infected with HBV? ☐Yes ☐No Patient is infected with HIV? ☐Yes ☐No
- All potential drug interactions with concomitant medications have been addressed: ☐Yes ☐No
- Does the member currently have issues with compliance? ☐Yes ☐No
- Provider attests that member has been counseled on barriers to Hepatitis C therapy, alcohol and illicit drug use: ☐Yes ☐No
- Provider attests that the member is committed to the treatment plan, including lab monitoring at 4, 8, and 12 weeks and SVR12 lab testing will be completed and submitted to health plan: ☐Yes ☐No
- Member's previous treatment history and response: _____
- Member completed treatment: ☐Yes ☐No
- Is the member cirrhotic? ☐Yes* ☐No *If Yes, provide Child Turcotte Pugh Class: ☐ Class A ☐Class B ☐ Class C
- Does member have hepatocellular carcinoma? ☐Yes* ☐No
  *If yes, confirmation of diagnosis was made by ultrasound, tomography, MRI, laparoscopy or biopsy: ☐Yes ☐No

**Member has ONE of the following: (All applicable documentation must be included with this request)**

- History of liver transplant: ☐Yes* ☐No *If Yes, date of transplant: _____
- Is HIV or HBV coinfected: ☐Yes ☐No
- Serious extrahepatic manifestations of Hepatitis C: ☐Yes ☐No
- A Metavir fibrosis score of F2-F4 documented by liver biopsy, Fibroscan or blood test **(copy of result REQUIRED)**:
  ☐Yes ☐No Fibrosis Level: _____
- Physical findings consistent with substantial or advanced fibrosis: ☐Yes ☐No

**Lab testing required (attach copy of results):**

- **Genotype** (with subtype if provided)_____
- **RASs testing as indicated in guidelines** (resistance-associated substitutions, previously called RAVs)

**Copies of the following lab testing results (completed within 3 months of starting therapy) MUST be submitted with request:**

- **Detectable HCV RNA viral load**
- **ALT/AST**
- **TSH** (ONLY if regimen contains interferon)
- **Pregnancy test** (**within 1 month** and ONLY if regimen contains ribavirin and the member is of child bearing age)
- **GFR**
- **INR**
- **CBC** (ONLY if regimen contains ribavirin)

**Provider Signature**: _____ **Date**: _____



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# DC Medicaid Beneficiary Disclosure and Commitment to Take Hepatitis C Medications

**Revised: February 23, 2017**

Please initial each statement that you have read and discussed the "Disclosure and Commitment to Take Hepatitis C Medications" form with your healthcare provider.

_____I understand that I will be taking very potent and expensive Hepatitis C medication(s). After discussion of the nature, alternatives, risks and benefits of these medications with my physician, I agree to take them as instructed. I understand that this combination of medication is to manage or cure my Hepatitis C and has shown a high chance of a successful response in the treatment of Hepatitis C when taken appropriately.

_____I understand that there are risks to not treating chronic Hepatitis C, including disease progression, developing cirrhosis, liver cancer and liver failure. I also understand there are risks and hazards related to the use of these medications. The risks and benefits have been reviewed and discussed with me by my prescriber.

_____I will commit to the following processes to help make this treatment successful:

☐ Daily adherence to medication unless told by prescriber/pharmacy to stop medication
☐ Timely laboratory monitoring per prescriber's request
☐ Medication Therapy Management (MTM) services provided by a DC Medicaid Program pharmacist, including an initial and all follow-up telephonic consultations relating to medication reviews, counseling, and education during and after the course of this treatment
☐ No missed follow-up appointments with prescriber regarding or during this treatment

_____I understand that if I am not committed to this regimen that I put myself in jeopardy with treatment failure and denial of medication coverage for this particular regimen by DC Medicaid, the insurance I have been given an opportunity to ask questions about my condition, alternative treatment options and risk of treatment and I believe that I have sufficient information to understand the content of this disclosure and commitment to this treatment option.

_____I understand that no warranty of guarantee has been made to me as a result of using this drug or the possibility of curing my condition. I acknowledge that I have been given a copy of this completed commitment form. I willingly give commitment to the following regimen: (Check all that apply below)

☐ Mavyret by mouth once daily.
☐ Daklinza by mouth once daily.
☐ Epclusa by mouth once daily.
☐ Harvoni by mouth once daily.
☐ Olysio 150 mg by mouth once daily.
☐ Sovaldi 400 mg by mouth once daily.
☐ Technivie by mouth once daily.
☐ Viekira Pak by mouth twice daily.
☐ Viekira XR by mouth once daily.
☐ Zepatier by mouth once daily.
☐ Ribavirin 200 mg: Take ____pills by mouth every morning and _____pills by mouth every evening.
☐ Pegylated Interferon Injection: Dose: ____injected in fat under skin once weekly.
☐ Projected start date if regimen is approved by insurance: _____Duration: ____weeks.

Patient Name: _____ Patient Signature: _____ Date: _____

Patient Phone Number: _____ Patient Email: _____

Prescriber's Signature: _____ Date: _____



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