CareFirst BlueCross BlueShield
Community Health Plan
District of Columbia
1100 New Jersey Ave SE
Suite 840
Washington, D.C. 2000**3**
www.carefirstchpdc.com

CareFirst Community Health Plan District of Columbia

Care First BlueCross BlueShield Community Health Plan District of Columbia
Member Education Commitment to Take Hepatitis C Medications

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

_____ I understand that I will be taking Mavyret, a very potent and expensive regimen. After discussion of the nature, alternatives risks and benefits of this medications with my physician, I agree to take it as instructed. I understand that this medication is to manage my Hepatitis C and has shown a high chance of a good response in the treatment 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 Counseling, Education and Training regarding administration and side effects
- ❑ Telephone follow-ups with prescriber, pharmacy and insurance
- ❑ No missed follow-up appointments with prescriber during this treatment

____ 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:

DHCF GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR
This program is funded in part by the Government of the District of Columbia Department of Health Care Finance

CareFirst BlueCross BlueShield
Community Health Plan
District of Columbia
1100 New Jersey Ave SE
Suite 840
Washington, D.C. 20003
www.carefirstchpdc.com

__ **Mavyret** by mouth once daily for_____weeks.
• Usually at bedtime

❑ **Projected start date if regimen is approved by insurance:** _____ **Duration:** _____ weeks.

Patient Signature: _____ Date: _____

Prescriber Signature: _____ Date: _____

This program is funded in part by the Government of the District of Columbia Department of Health Care Finance

CareFirst BlueCross BlueShield
Community Health Plan
District of Columbia
1100 New Jersey Ave SE
Suite 840
Washington, D.C. 2000**3**
www.carefirstchpdc.com

CareFirst Community Health Plan District of Columbia

Pharmacy Department

I. Required Medical Information:

A. All Information must be documented in the member's chart

a. Written documentation in the member's medical record of a diagnosis of Genotype 1,2,3,4,5, or 6 Infection
b. Written lab report documenting viral load
c. Written lab report documenting genotype
d. Complete past medical history of the member's previous treatment
e. The prescriber can be any physician who holds a current unrestricted license to practice medicine and is currently enrolled as a Medicaid Provider. If the prescriber is NOT a board-certified gastroenterologist, hepatologist or infectious disease specialist, a one-time written consultation report from a board-certified gastroenterologist, hepatologist or infectious disease specialist will be required within the past 3 months. This consulting specialist must have recommended Mavyret therapy prior to approval. Requests will not be accepted from mid-level practitioners and pharmacies
f. The prescriber agrees to submit progress notes and HCV RNA level to THP on patients prescribed Mavyret within the first 4 weeks of treatment, upon completion of therapy, and at 12 months post-treatment
g. Provider must provide a copy of a signed patient commitment letter for Mavyret treatment
h. If patient is female, she must not currently be pregnant and may not become pregnant while taking Mavyret. A negative pregnancy test must be obtained within the previous 30 days

DHCE GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR
This program is funded in part by the Government of the District of Columbia Department of Health Care Finance

CareFirst BlueCross BlueShield
Community Health Plan
District of Columbia
1100 New Jersey Ave SE
Suite 840
Washington, D.C. 20003
www.carefirstchpdc.com

CareFirst Community Health Plan District of Columbia

Initial Prior Authorization Request
Mavyret 100mg/40mg tablets

Request Date

Patient Medicaid ID Number

Patient's Date of Birth

Patient's Full Name

Prescriber's Full Name

Prescriber's Phone

Prescriber's Fax

Prescriber's NPI#

Prescriber's Email

Prescriber's Specialty

Summary of FDA approved Prescribing Information

Mavyret is a fixed dose combination of pibrentasvir, a hepatitis C virus (HCV) NS5A inhibitor, and glecaprevir, an HCV NS3/4A protease inhibitor, and is indicated with or without ribavirin for the treatment of chronic hepatitis C (CHC) genotype 1, 2, 3, 4, 5 or 6 infection in adults without cirrhosis and with compensated cirrhosis (Child-Pugh A). Please refer to FDA approved product information for prescribing details and approved indications.

Information Required for Prior Authorization Approval

1. Is the patient at least 18 years old? __Yes __No
2. Is the patient is cleared by their PCP for this therapy. __Yes __No
   Patient supervised by: __Infectious disease specialist __A gastroenterologist __A physician specialized in hepatitis treatment management __A physician/mid-level practitioner working in consultation with gastroenterologist or infectious disease specialist
3. Patient has a diagnosis of (please attach a letter of medical necessity with documentation):
   __Chronic Hepatitis C (CHC) monoinfection __Other: _____
4. Patient pretreatment HCV RNA level: _____ Date: _____
5. Patient has compensated liver disease: __Yes __No If yes, provide liver fibrosis assessment: _____
6. Patient has identified HCV genotype: __1 __2 __3 __4 __5 __6
7. Is the patient treatment naive? __Yes __No
8. Is MAVYRET to be used in combination with any other Hepatitis C medications?
   If yes, please explain: _____

DHCF GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR
This program is funded in part by the Government of the District of Columbia Department of Health Care Finance

CareFirst BlueCross BlueShield
Community Health Plan
District of Columbia
1100 New Jersey Ave SE
Suite 840
Washington, D.C. 20003
www.carefirstchpdc.com

9. Does the patient have a history of adherence problems to any prior therapy? __Yes __No
    a. (If yes): Briefly describe the nature of the problem (attach additional sheet if necessary)

    _____

    b. Please describe any educational efforts undertaken to improve patient's adherence (attach additional sheet if necessary)

    _____

    c. Has the patient been counseled on barriers to HCV therapy such as alcohol, and illicit drug use? __Yes __No
10. Is the patient on any one of the following medications: P-gp inducers, (e.g., rifampin or St. John's wort), carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifampin, atazanavir, rifabutin, rifapentine, tipranavir/ritonavir, cyclosporine, rosuvastatin, simeprevir or efavirenz containing regimens? __Yes __No
11. Has the patient been previously treated with any HCV therapy which included both an NS5A inhibitor and a NS3/4A protease inhibitor? __Yes __No
12. Has the patient tested negative for Hepatitis B (HBV)? __Yes __No
13. If MAVYRET is intended for use in pregnant women, has the patient been informed about the risks/benefits? __Yes __No
14. Fax to 866-839-2372:
    __Letter of Medical Necessity
    __CBC w/diff
    __HCV-RNA
    __Current pregnancy test
    __Patient Education & Commitment Form
    __Current creatinine clearance
    __Present and past documentation of illness (charts, biopsies, labs, etc.)
    __Present and past history of mental illness and antidepressant/antipsychotic use

I certify that, to the best of my knowledge, all information I have provided on this request is complete and factual.

Signature_____

Date _____

This program is funded in part by the Government of the District of Columbia Department of Health Care Finance