

**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 Sofosbuvir/Velpatasvir, 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:



__ Sofosbuvir/Velpatasvir by mouth once daily for _____ weeks.

- Usually at bedtime
- Choose the same day each week

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

Patient Signature: _____

Date: _____

Prescriber Signature: _____

Date: _____



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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 sofosbuvir-velpatasvir 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 sofosbuvir-velpatasvir 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 sofosbuvir-velpatasvir. A negative pregnancy test must be obtained within the previous 30 days



Initial Prior Authorization Request

Sofosbuvir/Velpatasvir 400mg/100mg tablets

Only Authorize when Mavyret is contraindicated

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

Epclusa is a fixed dose combination of sofosbuvir, a hepatitis C virus (HCV) NS5B inhibitor, and velpatasvir, an HCV NS5A 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. 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
The specialist supervising is: Infectious disease specialist A gastroenterologist A physician specialized in hepatitis treatment management.
3. Patient has a diagnosis of (please attach a letter of medical necessity with documentation):
 Chronic Hepatitis C monoinfection CHC/HIV-1 co-infection
 Hepatocellular carcinoma meeting Milan Criteria (Awaiting Liver Transplant Other: _____)
4. Patient has compensated liver disease: Yes No
5. Patient Fibrosis stage? _____ Child-Pugh Score: A B C
6. Patient has identified HCV genotype: 1a 1b 2 3 4
Other genotype _____



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7. 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)
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b. Describe any educational efforts undertaken to improve patient's adherence (attach additional sheet if necessary)

8. Is the patient on any one of the following medications: carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifabutin, rifampin, rifapentine, St. John's wort, efavirenz or tipranavir/ritonavir, Atazanavir? __Yes __No
9. Do both the patient and patient's partner plan to use two forms of effective contraception during treatment? __Yes __No
10. Has the patient agreed to abstain from illicit drug or alcohol use for at least six months and been counseled on potential barriers to adherence to HCV therapy? __Yes __No
If No, please give the reason(s) why.
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11. **Fax to 866-839-2372:** Letter of Medical Necessity CBC w/diff HCV-RNA Current pregnancy test Drug screening

__ 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 _____



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