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

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Member Education Commitment to Take Hepatitis C Medications (Non-formulary and Re-treatment)

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 ________________________, 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
- ❑ Medication Counseling, Education and Training regarding administration and side effects
- ❑ Telephone follow-ups with prescriber, pharmacy and insurance

___ 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 any future non-formulary HCV medication regimen by CareFirst Community Health Plan District of Columbia (CHPDC).

_____ I have been given an opportunity to ask questions about my condition, alternative treatment options including formulary agents as appropriate, 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:

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___ ___________________ 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: _____________

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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 agrees to submit progress notes and HCV RNA level to CHPDC on patients prescribed _______________________ within the first 4 weeks of treatment, upon completion of therapy, and at 12 months post-treatment
f. Provider must provide a copy of a signed patient commitment letter for the specified HCV treatment
g. If patient is female, she must not currently be pregnant and may not become pregnant while on HCV treatment. A negative pregnancy test must be obtained within the previous 30 days

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WE ARE WASHINGTON DC GOVERNMENT OF THE DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR

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Initial Prior Authorization Request

***Please note all DC Medicaid enrollee's qualify for treatment for Hepatitis C with Mavyret for 8 weeks.*
This form shall be used for all Retreatments and Non-Formulary requests

____
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

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 authorizing prescriber for this therapy. __Yes __No
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. Will the requested medication be taken in combination with any other Hepatitis C medications?
   If yes, please explain: ____

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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)
   ____
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 __Yes __No
12. Has the patient tested negative for Hepatitis B (HBV)? __Yes __No
13. If the HCV treatment 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 ____

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