HealthPartners

Hepatitis C Medication Coverage Request

Member name: Member ID: Date of Birth:

1. Regimen

   Primary Therapy: _____ Concurrent Therapy (if any): _____Total Duration: _____

   Proposed Start Date: _____ (Please be specific by listing target start date)

2. 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.

3. What is the patient's fibrosis stage? _____ What is the patient's HCV genotype? _____

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

5. Please list any HCV treatment regimens used previously:

Regimen	Dates	Response

6. Is the patient currently on a transplant list? _____ (if yes please answer questions a,b)

   a. Does the transplant specialist agree that the HCV treatment should be started now? _____

   b. Please indicate which specialist will continue to manage the HCV treatment _____

7. 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.
   b. prepared to adhere to the medication instructions, and understands the importance of adherence.
   c. willing and able to attend all necessary follow-up provider appointments and lab appointments.
   d. willing to participate in any health plan initiated outreach to ensure optimal outcomes.
   e. unlikely to require hospitalization for any type of elective procedure during the prescribed duration of therapy.
   f. at low risk for HCV re-infection.
   g. in a stable living condition and has evidence of active health insurance during entire course of treatment.
   h. likely to achieve a long term clinical benefit from HCV treatment.
   i. *likely to complete the HCV treatment and has discussed any concerns that may prevent completion of treatment with md.*

Provider signature _____ Date _____

Last update: 10/1/2016

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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 the costs for Epclusa®, Harvoni®, Sovaldi®, Zepatier®, Daklinza®, Olysio®, Technivie® and Viekira Pak/XR® are approximately $1,000 for each day of treatment.
2. I have received counseling and am prepared to take this medication as instructed.
3. I am willing and able to attend all necessary follow-up provider and lab appointments.
4. I am willing to participate in any health plan initiated outreach to ensure optimal outcomes.
   a.) The best number to reach me at during the day is _____
5. I agree to continue to abstain from all illegal and recreational drugs (including alcohol) while on the treatment regimen and will provide urine or blood specimens at the doctor's request to monitor my compliance.
6. I am highly motivated to achieve a cure and to refrain from behaviors that might lead to re-infection.
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 therapy 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 _____