Physician Request Form for Hepatitis C Therapies
Fax to Pharmacy Services at 1-855-829-2872, or call 1-855-251-0966
to speak to a representative. ***Form must be completed for processing***.

AmeriHealth Caritas Delaware

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: _____
Requested Medication name, strength, directions and duration: _____

Provider attests to all of the following:

- The member has received a complete Hepatitis B immunization series ☐Yes ☐No*
  *If No, the member has had a Hepatitis B screening (sAb, sAg and cAb) ☐Yes ☐No ☐N/A
  - If hepatitis B sAg positive the member has had a quantitative HBV DNA ☐Yes ☐No ☐N/A
    - If there is detectable HBV DNA there is a treatment plan consistent with AASLD recommendations ☐Yes ☐No ☐N/A
  - If negative for hepatitis B sAb there is a hepatitis B immunization plan or counseling to receive the hepatitis B immunization series ☐Yes ☐No ☐N/A
- The member has been screened for human immunodeficiency virus (HIV) and confirmatory testing as applicable: ☐Yes ☐No
  - If the member is confirmed positive for HIV are they being treated with antiretroviral therapy? ☐Yes ☐No* ☐N/A
    - If no, please provide the reason they are not being treated: _____
- All potential drug interactions with concomitant medications have been addressed: ☐Yes ☐No
- Member compliance: ☐Member does not have compliance issues ☐Member has compliance issues
- If the member is actively abusing alcohol or IV drugs or has a history of abuse has the member been counseled regarding the risks of alcohol or IV drug abuse and has an offer of referral for substance abuse disorder treatment been made? ☐Yes ☐No ☐N/A
- The member is committed to the treatment plan, including lab monitoring and SVR12 lab testing will be completed and submitted to health plan: ☐Yes ☐No
- Please provide the member's previous hepatitis C treatment history and response:
  _____
- The member completed hepatitis C treatment: ☐Yes ☐No
- Fibrosis Level: _____
- Is the member cirrhotic? ☐Yes* ☐No *If yes, provide Child Turcotte Pugh Class: ☐Class A ☐Class B ☐ Class C

Lab testing required (<u>attach copy of results/MUST be submitted with request</u>):

- **Genotype** (with subtype if provided): _____
- **RASs testing as indicated in guidelines** (resistance-associated substitutions, previously called RAVs)
- **Detectable HCV RNA viral load**
- **Pregnancy test** (<u>within 1 month and ONLY if regimen contains ribavirin and the member is of child bearing age</u>)
- **CBC (only if regimen contains ribavirin)**
- **TSH (only if regimen contains interferon)**

- Request includes the Delaware Medicaid and Medical Assistance Informed Consent for Hepatitis C therapy signed by member*:
  ☐Yes ☐No ***Member must sign and date next page of form. If member was seen via telehealth see instructions below form.***
- If request is for a non-preferred agent, documentation of medical necessity has been provided including the medical reason the member is not able to use a preferred agent: _____

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Prescriber Signature: _____ **Print Name:** _____ **Date**: _____

DELAWARE MEDICAID and MEDICAL ASSISTANCE (DMMA) INFORMED CONSENT FORM FOR HEPATITIS C THERAPY

This document is to help you understand the drugs being used to treat hepatitis C.

- You must take all of these medications for the full course of therapy (8-16 weeks). If you stop one, then the other will not work and it will need to be stopped as well.
- One of the commonly used medications is ribavirin. Ribavirin often has side effects. You may have flu like symptoms throughout the treatment. If severe side effects happen while taking ribavirin, you need to contact the physician's office for direction.
- The medicines used to treat hepatitis C are harmful during pregnancy. A baby may have serious birth defects or die if exposed during the pregnancy to these medicines. Contraceptive (birth control) measures must be used by females and males receiving these medicines to prevent severe birth defects or fetal deaths. The medicine may impact the unborn child for up to 6 months after it has been stopped.
    - Females: You are asked to provide information on two contraceptive methods (birth control) being used to avoid getting pregnant.
    - Males: While you are taking this drug, your partner must avoid becoming pregnant. Together you must use two contraceptive (birth control) methods. You are asked to provide information on two contraceptive methods (birth control) being used to avoid pregnancy.
- Alcohol must be avoided to prevent further harm to the liver. The use of alcohol during treatment may lead to coverage of medications being cancelled.
- Illegal substance must be avoided. Exposure to another form of Hepatitis C would make it more challenging to treat the viral infection.
- If you fail to strictly follow the drug regimen, it may not be effective.

By signing this document, I acknowledge that I have read the above information, that I will abide by all parts of it, and that failure may result in termination of my medication for hepatitis C.

MEMBER PRINTED NAME:_____
MEMBER SIGNATURE: _____
DATE:_____

- If the member was seen via telehealth, the provider should initial below to indicate that the DMMA Informed Consent Form for Hepatitis C Therapy was reviewed with the member:

Provider Initials: _____

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