SoonerCare
Oklahoma Health Care Authority

Pharmacy Services

(800) 522-0114, option 4

June 27, 2014

RE: Prior Authorization of Sovaldi™, Olysio™, Victrelis®, and Incivek® for the treatment of Hepatitis C

Dear Pharmacist,

The Oklahoma Health Care Authority (OHCA) anticipates that a Prior Authorization requirement will be implemented July 1, 2014 for coverage of **Sovaldi™, Olysio™, Victrelis®, and Incivek®** for the treatment of Hepatitis C.

The PA criteria for these medications can be found at www.okhca.org/pa. Click on the link that says "Hepatitis C."

Due to the nature of the treatment regimen and expense, additional documentation is required before authorization will be granted. For each new start, please submit the

- Treatment Initiation Prior Authorization Form
  - Sovaldi™ (PHARM-26); or
  - Olysio™ (PHARM-27)
- Patient Consent and Intent to Treat Contract (PHARM-28)
- Pharmacy Agreement (PHARM-29)

A Continuation of Therapy Form (PHARM-30) is required with each refill to assure the patient is adhering to the prescribed regimen. These forms are required for all patients refilling one of these medications after July 1, 2014. These forms can all be found at www.okhca.org/rx-forms.

SoonerCare records indicate your pharmacy NPI has been listed on paid claims for one of these medications (Sovaldi™, Olysio™, Victrelis®, and Incivek®). Any new patient that plans to start on these medications will need the above forms, and any patient who has not completed therapy with these medications will need a Continuation of Therapy Form for their refills to be approved.

If you have any questions please contact the pharmacy help desk at (800) 522-0114, option 4.

Thank you for your continued service to Oklahoma's SoonerCare members.

SoonerCare Pharmacy Services • Pharmacy Management Consultants • PO Box 26901; ORI W-4403 • Oklahoma City, Oklahoma 73126-0901 • Phone: (800) 522-0114, option 4 • Fax: (800) 224-4014

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Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority

Hepatitis C Therapy Continuation Prior Authorization Form

Member Name: _____ ***Date of Birth:***_____ ***Member ID#:***_____
Pharmacy Name:_____ ***Pharmacy NPI:***_____
Pharmacy Phone: _____ ***Pharmacy Fax:***_____
Pharmacist Name:_____ ***Prescriber Name:*** _____
Prescriber NPI: _____ ***Specialty:***_____
Prescriber Phone:_____ ***Prescriber Fax:*** _____

Pharmacy Section

Member's Hepatitis C Therapy Regimen:_____

_____

Drug Name:_____ ***NDC:***_____

Today's Date:_____ ***Date Prescription Last Filled:***_____
Date Member Took First Dose:_____ ***Expected End Date:***_____

Number of doses remaining today: _____ ***Refill Number:***_____

Did the member fill pegylated interferon? ***Yes____ No_____***
Date pegylated interferon last filled: _____ ***Remaining Supply:***_____

Did the member fill ribavirin? ***Yes____ No_____***
Date ribavirin last filled: _____ ***Remaining Supply:***_____

Pharmacist Signature: **Date:**

Prescriber Section

Initial Viral Load_____ ***Date Tested:*** _____

Recent Viral Load_____ ***Date Tested:*** _____

Recent Urine Drug Screen? ***Yes____ No____*** ***Date Tested:*** _____

Monthly Pregnancy Test?** ***Yes____ No____ NA____*** ***Date Tested:*** _____

***Required for female members and female partners of male members.*

Has the member experience any adverse drug reactions related to hepatitis C therapy?

Yes____ No____

If yes, please specify reactions: _____

_____

Prescriber Signature: _____ **Date:** _____

Please do not send in chart notes. Specific information/documentation will be requested if necessary.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

CONFIDENTIALITY NOTICE