

**State of Oklahoma  
Oklahoma Health Care Authority  
Olysio™ Initiation Prior Authorization Form**

**Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_  
**Pharmacy NPI:** \_\_\_\_\_ **Pharmacy Phone:** \_\_\_\_\_ **Pharmacy Fax:** \_\_\_\_\_  
**Pharmacy Name:** \_\_\_\_\_ **Pharmacist Name:** \_\_\_\_\_  
**Prescriber NPI:** \_\_\_\_\_ **Prescriber Name:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_  
**Prescriber Phone:** \_\_\_\_\_ **Prescriber Fax:** \_\_\_\_\_ **Drug Name:** \_\_\_\_\_  
**NDC:** \_\_\_\_\_ **Start Date:** \_\_\_\_\_

**Clinical Information**

1. HCV Genotype (including subtype): \_\_\_\_\_ Date Determined: \_\_\_\_\_
  2. METAVIR Equivalent Fibrosis Stage: \_\_\_\_\_ Testing Type: \_\_\_\_\_  
Date Fibrosis Stage Determined: \_\_\_\_\_
  3. Pre-treatment viral load in the last 12 months: \_\_\_\_\_ Date Taken: \_\_\_\_\_  
For METAVIR score of <F1, 2nd test must confirm chronic HCV diagnosis at least 6 months after 1st test.  
Prior pre-treatment viral load or antibody test: \_\_\_\_\_ Date Taken: \_\_\_\_\_
  4. Does member have decompensated hepatic disease (CTP class B or C)? Yes \_\_\_ No \_\_\_
  5. Is the member currently on hospice or does the member have a limited life expectancy (less than 12 months) that cannot be remediated by treating HCV? Yes \_\_\_ No \_\_\_
  6. Has the member been evaluated by a gastroenterologist, infectious disease specialist, or a transplant specialist within the past 3 months? Yes \_\_\_ No \_\_\_
  7. If yes, please include name of specialist recommending hepatitis C treatment: \_\_\_\_\_
  8. Has the member been previously treated for hepatitis C? Yes \_\_\_ No \_\_\_
  9. If yes, please indicate previous treatment regimen and reason for failure (relapser, null-responder, partial responder): \_\_\_\_\_
  10. Please indicate regimen below (a separate initiation form will need to be filled out for Sovaldi™):
    - Olysio™ with Sovaldi™ with or without weight-based ribavirin for 12 weeks
    - Olysio™ with Sovaldi™ with or without weight-based ribavirin for 24 weeks
    - Other: \_\_\_\_\_
  11. Will the member be taking ribavirin with their regimen? Yes \_\_\_ No \_\_\_
  12. Has the member signed the intent to treat contract\*\*\*? Yes \_\_\_ No \_\_\_ *\*\*Required for processing of request.*
  13. Has the member been counseled on the harms of illicit IV drug use and alcohol use and agreed to not use illicit IV drugs or alcohol while on or after they finish hepatitis C treatment? Yes \_\_\_ No \_\_\_
  14. Has the member initiated immunization with the hepatitis A and B vaccines? Yes \_\_\_ No \_\_\_
  15. For women of childbearing potential (and male patients with female partners of childbearing potential):
    - Patient is not pregnant (or a male with a pregnant female partner) and not planning to become pregnant during treatment or within 6 months of completing treatment
    - Agreement that partners will use two forms of effective non-hormonal contraception during treatment and for at least 6 months after completing treatment  
Please list non-hormonal birth control options discussed with member \_\_\_\_\_
    - Verification that monthly pregnancy tests will be performed throughout treatment
  16. Is the member taking any of the following medications: efavirenz, delavirdine, etravirine, nevirapine, ritanovir, any HIV protease inhibitor, rifampin, rifabutin, rifapentine, erythromycin, clarithromycin, telithromycin, carbamazepine, oxcarbazepine, eslicarbazepine, phenobarbital, phenytoin, itraconazole, ketoconazole, posaconazole, fluconazole, voriconazole, dexamethasone, cisapride, didanosine, milk thistle, or St. John's wort? Yes \_\_\_ No \_\_\_
  17. Have all other clinically significant issues been addressed prior to starting therapy? Yes \_\_\_ No \_\_\_
- This patient is in need of additional support. I recommend this patient be followed by an OHCA Care Management Nurse.  
**Members must be adherent for continued approval. Treatment gaps of therapy longer than 3 days will result in denial of payment for subsequent requests for continued therapy. Refills must be prior authorized.**

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Has the member been counseled on appropriate use of Olysio™ therapy? Yes \_\_\_ No \_\_\_

**Pharmacist Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Please do not send in chart notes. Specific information/documentation will be requested if necessary. Failure to complete this form in full will result in processing delays. By signature, the prescriber or pharmacist confirms the above information is accurate.*

**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

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