SoonerCare
Oklahoma Health Care Authority

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. Diagnosis: _____ HCV Genotype (including subtype):_____
2. For those with genotype 1a, do they have the NS3 Q80K polymorphism? Yes___ No___
3. METAVIR Fibrosis Stage: _____ Date Determined: _____
4. Does member have decompensated hepatic disease (CTP class B or C)? Yes___ No___
5. Has the member been evaluated by a gastroenterologist, infectious disease specialist, or a transplant specialist within the past 3 months? Yes___ No___
6. If yes, please include name of specialist recommending hepatitis C treatment: _____
7. Please indicate regimen below (if member is IFN ineligible please specify reasoning):
   - ☐ Olysio™ 150mg daily w/ weight-based RBV plus weekly PEG/IFN x 84 days (12 weeks) followed by 12 additional weeks of weight-based RBV plus weekly PEG/IFN
   - ☐ Olysio™ 150mg daily w/ weight-based RBV plus weekly PEG/IFN x 84 days (12 weeks) followed by 36 additional weeks of weight-based RBV plus weekly PEG/IFN
   - ☐ Other:_____**

   ***Please supply reference citation to support requested therapy.*
8. Has the member previously failed treatment with a hepatitis C protease inhibitor (Victrelis® or Incivek®)? Yes___ No___
9. Has the member signed the intent to treat contract**? Yes___ No___
   ***Required for processing of prior authorization request.*
10. Has the member had illicit IV drug use or alcohol abuse in the last 6 months? Yes___ No___
11. Has the member initiated immunization with the hepatitis A and B vaccines? Yes___ No___
12. 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
13. 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___
14. Have all other clinically significant issues been addressed prior to starting therapy? Yes___ No___

☐ 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.

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