

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

- HCV Genotype (including subtype): _____ Date Determined: _____
- METAVIR Equivalent Fibrosis Stage: _____ Testing Type: _____
Date Fibrosis Stage Determined: _____
- Pre-Treatment Viral Load: _____ Date Determined: _____
- Does member have decompensated hepatic disease (CTP class B or C)? Yes ___ No ___
- Has the member been evaluated by a gastroenterologist, infectious disease specialist, or a transplant specialist within the past 3 months? Yes ___ No ___
- If yes, please include name of specialist recommending hepatitis C treatment: _____
- Has the member been previously treated for hepatitis C? Yes ___ No ___
- If yes, please indicate previous treatment regimen and reason for failure (relapser, null-responder, partial responder): _____
- 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: _____ **

**Please supply reference citation to support requested therapy.

- Will the member be taking ribavirin with their regimen? Yes ___ No ___
- Has the member signed the intent to treat contract**? Yes ___ No ___ **Required for processing of request.
- Has the member had illicit IV drug use or alcohol abuse in the last 6 months? Yes ___ No ___
- Has the member initiated immunization with the hepatitis A and B vaccines? Yes ___ No ___
- 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
- 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 ___
- 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. Failure to complete this form in full will result in processing delays.

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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