OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare

Hepatitis C Therapy Intent to Treat Contract

Member Name: _____ ***Date of Birth:***_____ ***Age:*** _____ ***years*** _____***months***

Member ID#:_____***Prescriber NPI:*** _____ ***Prescriber Name:*** _____

Specialty:_____ ***Prescriber Phone:***_____ ***Prescriber Fax:*** _____

Drug Name:_____ ***Hepatitis C Regimen:***_____

To be completed by member after discussion of therapy with prescriber.
Contract is required for processing of prior authorization requests.

Please initial after each line and sign at the bottom. Please complete all applicable blanks.

1. I am ready to start treatment on the following date:_____ **Initials**_____
2. I have been counseled on how to take hepatitis C medications and understand how to take my medications, the potential side effects, and importance of finishing all of the therapy. **Initials**_____
3. I will take my medications exactly how my doctor instructed and I will not miss doses. **Initials**_____
4. I understand that if I miss taking my medications more than 3 days in a month SoonerCare will no longer provide payment for my hepatitis C medications. **Initials**_____
5. My prescriber has counseled me on the harms of alcohol use and illicit intravenous (IV) drug use. **Initials**_____
6. I am not pregnant or my female partner is not pregnant. **Initials**_____
7. I am not planning to become pregnant or my female partner is not planning to become pregnant during treatment or within 6 months of completing treatment. **Initials**_____
8. I will use the following <u>two</u> forms of effective non-hormonal birth control during treatment and for at least 6 months after completing treatment:_____ **Initials**_____
9. If my treatment includes ribavirin, I will undergo monthly pregnancy tests throughout treatment (female members only) or my female partner will undergo monthly pregnancy tests throughout my treatment. **Initials**_____
10. I have discussed all medications I am currently taking or plan to take with my hepatitis C prescriber including over the counter medications and supplements. **Initials**_____
11. I do not have other medical issues that will prevent me from taking my treatment as prescribed. **Initials**_____
12. I have a pending Medicare/Social Security disability case. **Yes**☐ **No**☐ **Initials**_____
13. I understand this hepatitis C treatment will use up to 3 “punches”/prescriptions of my 6 total allowed per month by SoonerCare. **Initials**_____
14. I will work with <u>one</u> pharmacy to make sure my SoonerCare pharmacy benefit is used correctly during my treatment for hepatitis C. **Initials**_____

Pharmacy Name_____ **Phone**_____

I have read the above statements, and I understand the agreement.

Member Signature: _____ **Date:** _____

Prescriber Signature: _____ **Date:** _____
Required for processing prior authorization request.
By signature, the member or prescriber confirms the above information is accurate.

<u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u>

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