SoonerCare
Oklahoma Health Care Authority

# State of Oklahoma
# Oklahoma Health Care Authority
# Technivie™ (Ombitasvir/Paritaprevir/Ritonavir) 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 or Child-Pugh 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 for hepatitis C therapy 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 requested regimen below:
    - ❑ Technivie™ with weight-based RBV x 84 days (12 weeks)
    - ❑ Other:_____
11. Has the member signed the intent to treat contract**? Yes___ No___ ***Required for processing of request*
12. 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____
13. Has the member initiated immunization with the hepatitis A and B vaccines? Yes___ No___
14. 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
    - ❑ 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
15. Is the member taking any of the following medications: alfuzosin, carbamazepine, phenytoin, phenobarbital, rifampin, ergotamine, dihydroergotamine, ergonovine, methylergonovine, ethinyl estradiol containing medications (combined oral contraceptives), St. John's wort, lovastatin, simvastatin, pimozide, efavirenz, sildenafil, triazolam, orally administered midazolam, atazanavir/ritonavir, darunavir/ritonavir, lopinavir/ritonavir, rilpivirine, salmeterol, & voriconazole? Yes____ No____
16. Have all other clinically significant issues been addressed prior to starting therapy? Yes____ No_____
17. Will the member's ALT levels be monitored during the first four weeks of starting treatment and as clinically indicated thereafter? 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 Technivie™ 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