



### Wyoming Medicaid Client Disclosure and Commitment to Take Hepatitis C Medications

Please initial each statement that you have read and discussed the “Disclosure and Commitment to Take Hepatitis C Medications” form with your healthcare provider.

\_\_\_ I understand that I will be taking very potent and expensive Hepatitis C medication(s). After discussion of the nature, alternatives, risks and benefits of these medications with my prescriber, I agree to take them as instructed. I understand that this combination of medication is to manage my Hepatitis C and has shown a high chance of a successful response in the treatment of Hepatitis C when taken appropriately.

\_\_\_ I understand that there are risks to not treating chronic Hepatitis C, including disease progression, developing cirrhosis, liver cancer and liver failure. I also understand there are risks and hazards related to the use of these medications. The risks and benefits have been reviewed and discussed with me by my prescriber.

\_\_\_ I will commit to the following processes to help make this treatment successful:

- Daily adherence to medication unless told by prescriber/pharmacy to stop medication
- Timely laboratory monitoring per prescriber’s request
- Medication counseling, education and training regarding administration and side effects
- Telephone follow-ups with prescriber, pharmacy, Medicaid and WyHealth
- No missed follow-up appointments with prescriber during this treatment

\_\_\_ I understand that if I am not committed to this regimen that I put myself in jeopardy with treatment failure and denial of medication coverage for this particular regimen by Wyoming Medicaid. I understand that only one course of therapy is allowed in my Wyoming Medicaid lifetime.

\_\_\_ I have been given an opportunity to ask questions about my condition, alternative treatment options and risks of treatment, and I believe that I have sufficient information to understand the content of this disclosure and commitment to this treatment option.

\_\_\_ I understand no warranty of guarantee has been made to me as a result of using this drug of the possibility of curing my condition. I acknowledge that I have been given a copy of this completed commitment form. I willingly give commitment to the following regimen.

- Sovaldi 400 mg** by mouth once daily
- Olysio 150 mg** by mouth once daily
- Harvoni (90 mg ledipasvir/400 mg sofosbuvir)** by mouth once daily
- Viekira Pak** by mouth as directed (Two ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg tablets every morning, one dasabuvir 250 mg tablet twice daily)
- Daklinza 60 mg** by mouth once daily with **Sovaldi 400 mg** by mouth once daily
- Zepatier 50/100 mg** by mouth once daily
- Epclusa 400/100 mg** by mouth once daily
- Ribavirin 200 mg** Take \_\_\_\_\_ pills by mouth every morning and \_\_\_\_\_ pills by mouth every evening
- Pegylated Interferon Injection** Dose: \_\_\_\_\_ injected in fat under skin once weekly

Projected start date if regimen is approved by insurance: \_\_\_\_\_ Duration: \_\_\_\_\_ weeks

Patient Name: \_\_\_\_\_ Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I, the undersigned prescriber, do hereby affirm that I have disclosed all of the above statements with full explanation to the patient. I have specifically explained that Wyoming Medicaid will only cover one such treatment for the patient, and non-compliance with the prescribed Hepatitis C regimen may put the patient in jeopardy for denial of coverage in the future.

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

Please fax to 866-964-3472 or upload completed form with the Hepatitis C prior authorization request to Change Healthcare. For any other questions, please call the Change Healthcare Help Desk at 877-209-1264.