

# 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 and I will not use alcohol or illicit IV drugs while on my hepatitis C medications or after I finish my hepatitis C medications. **Initials** \_\_\_\_\_
6. I will not use alcohol or illicit IV drugs while on treatment or after completion of therapy. **Initials** \_\_\_\_\_
7. I understand that random drug testing is required. **Initials** \_\_\_\_\_
8. I am not pregnant or my female partner is not pregnant. **Initials** \_\_\_\_\_
9. 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** \_\_\_\_\_
10. I will use the following two forms of effective non-hormonal birth control during treatment and for at least 6 months after completing treatment: \_\_\_\_\_ **Initials** \_\_\_\_\_
11. I will undergo monthly pregnancy tests throughout treatment (female members only) or my female partner will undergo monthly pregnancy tests throughout my treatment. **Initials** \_\_\_\_\_
12. 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** \_\_\_\_\_
13. I do not have other medical issues that will prevent me from taking my treatment as prescribed. **Initials** \_\_\_\_\_
14. I have a pending Medicare/Social Security disability case. **Yes** \_\_\_\_\_ **No** \_\_\_\_\_ **Initials** \_\_\_\_\_
15. I understand this hepatitis C treatment will use up to 3 "punches"/prescriptions of my 6 total allowed per month by SoonerCare. **Initials** \_\_\_\_\_
16. I will work with one 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.*

<p>Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at <a href="http://AetnaBetterHealth.com/Oklahoma">AetnaBetterHealth.com/Oklahoma</a>.</p>	<p><b>CONFIDENTIALITY NOTICE</b> <i>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</i></p>
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