SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Hepatitis C Therapy Pharmacy Agreement

Member Name: _____ ***Date of Birth:***_____ ***Member ID#:***_____

Pharmacy NPI: _____ ***Pharmacy Name:*** _____

Pharmacy Phone:_____ ***Pharmacy Fax:*** _____ ***Drug Name:***_____

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

The member will start treatment on the following date:_____

Please check each line and sign at the bottom.

- ❑ The member has been counseled on hepatitis C medications including the following:
  - ❑ Regimen
  - ❑ Potential side effects
  - ❑ Storage requirements
  - ❑ Importance of compliance
  - ❑ Drug interactions
  - ❑ SoonerCare prescription limits and the need for appropriate "punches" per month
- ❑ The member has been counseled on effective non-hormonal birth control products. Please list non-hormonal birth control options discussed with member_____
- ❑ The pharmacist agrees to contact the member and prescriber 7 days before medications run out to start the prior authorization process for refills.
- ❑ The pharmacist agrees to obtain an accurate dose count (no estimating) when discussing refills.
- ❑ The pharmacist agrees to notify the prescriber and OHCA if the member is non-compliant within 1 day of late refills.
- ❑ The pharmacist agrees to refuse to fill hepatitis C therapies without appropriate combination therapy as indicated on the prior authorization form.
- ❑ The pharmacist agrees to work with member to appropriately utilize SoonerCare pharmacy benefits including therapy management, transferring prescriptions, and working with OHCA and other pharmacies to stretch the benefit when required.
- ❑ I have read the above statements, and understand the agreement.

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.

I recommend this patient be followed by an OHCA Care Management Nurse. **Initials:**_____

Pharmacist Signature: _____ **Date:** _____
By signature, the pharmacist confirms the information above is accurate.
Required for processing prior authorization request.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
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	*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.*