GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Health Care Finance

DC Medicaid Beneficiary 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 physician, 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 and insurance
□ 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 DC Medicaid, the insurance. I understand that only one course of therapy is allowed in his/her DC Medicaid lifetime.

____ I have been given an opportunity to ask questions about my condition, alternative treatment options and risk 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 that no warranty of guarantee has been made to me as a result of using this drug or 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:

□ **Harvoni** by mouth once daily.
□ **Viekira Pak (2** of the fixed combination tablets once daily (in the morning) and one dasabuvir 250 mg tablet twice daily.
□ **Sovaldi 400mg** by mouth once daily.
□ **Olysio 150mg** by mouth once daily.
□ **Harvoni** by mouth once daily.
□ **Ribavirin 200mg** 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: _____

Prescriber Signature: _____ Date: _____

Please fax completed form to DC Pharmacy Benefit Manager: 866 535-7622. For any other questions please call the helpdesk: 800-273-4962