

## DC Medicaid Beneficiary Disclosure and Commitment to Take Hepatitis C Medications

Revised: February 23, 2017

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 or cure 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 Therapy Management (MTM) services provided by a DC Medicaid Program pharmacist, including an initial and all follow-up telephonic consultations relating to medication reviews, counseling, and education during and after the course of this treatment
- No missed follow-up appointments with prescriber regarding or 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 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: (Check all that apply below)

- ☐ **Daklinza** by mouth once daily.
- ☐ **Epclusa** by mouth once daily.
- ☐ **Harvoni** by mouth once daily.
- ☐ **Olysio 150 mg** by mouth once daily.
- ☐ **Sovaldi 400 mg** by mouth once daily.
- ☐ **Technivie** by mouth once daily.
- ☐ **Viekira Pak** by mouth twice daily.
- ☐ **Viekira XR** by mouth once daily.
- ☐ **Zepatier** 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: \_\_\_\_\_

Patient Phone Number: \_\_\_\_\_ Patient Email: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_