**Direct-Acting Antiviral (DAA) Agents Used to Treat Chronic Hepatitis C Virus (HCV)**
**Treatment Agreement for Louisiana Medicaid Recipients**

Prescriber Instructions: Please submit the completed treatment agreement with the initial clinical authorization request for the **non-preferred** Direct-Acting Antiviral Agent(s) (DAA) for Hepatitis C.

| **Patient Information** | **Prescriber Information** | |
|---|---|---|
| Recipient Name: | Prescriber Name: | |
| Medicaid Recipient ID #: | Medicaid Provider ID # or NPI: | |
| Date of Birth: | Office Contact: | |
| Hepatitis C Medication Regimen: | Provider Phone Number: | Provider Fax Number: |

| Patient Instructions: Please read this treatment agreement carefully. Please initial each item to show you have read and understand it. Be sure to ask any questions you have before you sign it. Sign and date at the bottom of the form. | | **Patient's Initials** |
|---|---|---|
| 1. | I have been told how to take my hepatitis C medicines. I understand how to take them. I am aware of possible side effects. I understand why it is important to finish all the therapy. | |
| 2. | I will take my hepatitis C medicines like my doctor said. I will not miss doses. | |
| 3. | I will tell my doctor and pharmacist the medicines I take. I understand there may be some medicines I cannot take with my hepatitis C medicines. | |
| 4. | If I am taking ribavirin, I am (OR my female partner is) not pregnant. | |
| 5. | If I am taking ribavirin, I am (OR my female partner is) not planning on getting pregnant while I am on my hepatitis C medicines and for at least 6 months after I finish them. | |
| 6. | If I am taking ribavirin, I (OR my female partner) will use two forms of effective contraception while I am taking my hepatitis C medicines and for at least 6 months after I finish them. | |
| 7. | If I am taking ribavirin, I (OR my female partner) will have monthly pregnancy testing while I am taking my hepatitis C medicines. | |

**I have read the above statements and understand the agreement.**

**Patient Signature:**_____ **Date:**_____

**Physician Signature:**_____ **Date:**_____