

Hepatitis C Prior Authorization and Case Management Referral Form

Fax this completed form to 541.677.5881

** Required Field*

Date of Request: ____/____/____

MEMBER INFORMATION

*Member Name: _____ *Member ID: _____ *Member DOB: _____

PROVIDER INFORMATION

*Provider Name: _____ MD DO FNP NP PA *NPI: _____

*Office Contact Person: _____ *Phone #: _____ *Fax #: _____

MEDICATION INFORMATION

*Drug name, strength, and form: _____ *Directions: _____ *Qty per Day: _____

*Expected Length of Treatment: _____

DIAGNOSIS INFORMATION

*Diagnosis Code(s): _____

DOCUMENTATION

Please provide the following information and all related documents:

*Is expected survival from non-HCV-associated morbidities more than 1 year? Yes No Date: _____

*Does the patient have a history of HCV Treatment? Yes No Drug Regimen: _____

- If past treatment was failed, was adherence with medication a concern: Yes No Not sure

HCV Genotype (drawn <3 years, if applicable to regimen) Date: _____ Result: _____

*HBV Status Date: _____ Result: _____

HIV Status Date: _____ Result: _____

Baseline NS5a resistance test (if applicable to regimen) Date: _____ Result: _____

*Cirrhosis Status: Present (Compensated Decompensated) Absent (Non-cirrhotic)

*Does the patient have complications of cirrhosis, or other hepatic manifestations? Yes No

- If yes, explain: _____

Child-Pugh Score (if applicable to regimen): _____

Stage of Fibrosis Method of testing (i.e., biopsy, etc.): _____ Date: _____ Result: _____

Does the patient have any drug interactions that have been addressed? Yes No

- If yes, explain: _____

***UHA Case Management:** Is there attestation that the patient and provider will comply with UHA case management to promote the best possible outcome for the patient and adhere to monitoring requirements required by the Oregon Health Authority, including measuring and reporting of a post-treatment viral load OR is there attestation from the patient and provider that they have opted out of UHA case management? Yes No

Questions? For assistance with this form, call UHA Clinical Pharmacy Services at 541-672-1685 or UHA Case Management at 541.229.7037