

CareOregon Advantage
Hepatitis C Therapy Request Form
FAX to 503-416-8109

Revised 5/12/2017



315 SW Fifth Avenue
 Portland, OR 97204
 503-416-4279 or 1-888-712-3258
 (TTY/TDD) 7-1-1
 www.careoregonadvantage.org

For assistance with this form, call CareOregon Advantage at 503.416.4279 or toll-free at 888.712.3258, Monday through Friday from 8 am - 8 pm. Please mark URGENT only as necessary as it delays the review of other requests that may seriously jeopardize the health of another member. To view our drug policies, search through the [Prior Authorization Criteria](#).

**** Please complete all fields legibly and we recommend providing supporting medical records ****

<small>A standard request may take up to 72 hours to process, but the average process time is less than 24 hours.</small>		
<input type="checkbox"/> URGENT REQUEST Initial response within 24 hours (Should be reserved for those actively on treatment or in transplant setting)		
Patient Name:	Prescriber Name:	
Member ID #:	NPI#:	
Patient DOB:	Clinic Name:	
Pharmacy Name:	Prescriber Office Phone:	Prescriber Office Fax:
Pharmacy Phone:	Prescriber Contact Person:	
Hepatitis C Drugs Requested (include all in regimen including strength)		Frequencies:
<input type="checkbox"/> Zepatier 50-100 MG TABLET (Preferred for Genotype 1 and 4)		
<input type="checkbox"/> Epclusa 400-100 MG TABLET (Preferred for Genotype 2, 3, 5, 6)		
<input type="checkbox"/> Other:		
<input type="checkbox"/> Other:		
Desired Length of Treatment:	Estimated Start Date of Treatment: <input type="checkbox"/> Already Started on:	
<u>Past Treatment History</u>		
Does the patient have a history of HCV treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes; Drug Regimen: _____ Outcome?: <input type="checkbox"/> Relapse <input type="checkbox"/> Non-Response <input type="checkbox"/> Adverse Event		
Patient's HCV Genotype:	Quantitative HCV RNA:	
Does the patient have co-morbid HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have co-morbid Hepatitis B? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Stage of fibrosis and method of testing (ie Biopsy, Fibroscan, Fibrosure, Clinical Diagnosis):		Date:
<u>Cirrhosis status:</u> <input type="checkbox"/> Compensated <input type="checkbox"/> Decompensated <input type="checkbox"/> NA (not cirrhotic)	<u>Related to Liver Transplant?</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Alcohol and Drug Abuse (clinical records documentation required)?</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Recovery Program	Resistance Testing Completed? (Required for Zepatier) <input type="checkbox"/> Yes (please attach) <input type="checkbox"/> No	
CareOregon recommends all prior authorizations be submitted with supporting medical records to help for a faster and more thorough review (include resistance testing if applicable)		
Additional supporting information:		
Prescribers Signature:		Date:

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