

Hepatitis C Prior Authorization Request Form

FAX Request Form to 503-416-8109

For assistance with this form, you may call CareOregon at 503-416-4100 or 800-224-4840, Monday through Friday from 8 am - 5 pm. To view our drug policies, search through the [PA Criteria Document](#).

A standard request will be processed within 24 hours unless a request for additional information is made.		
<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)		Desired length of treatment:
Past treatment history		
Does the patient have a history of HCV treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes; drug regimen: _____		
If past treatment failed, was adherence with medication a concern? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure		
Quantitative HCV RNA (Test w/in 6 months):		Date:
Patient's HCV genotype:		Date:
Cirrhosis status: <input type="checkbox"/> Compensated <input type="checkbox"/> Decompensated <input type="checkbox"/> NA (not cirrhotic)		
Resistance testing completed? <input type="checkbox"/> Yes (please attach) <input type="checkbox"/> No		
Required documentation on case management: Please identify what elements of case management your clinic offers. Failure to completely fill out this table could result in delay of processing the PA.		
Care management service	The prescriber clinic offers	Needs CCO support
Has an assigned team or case manager as the member's point of contact.		
Assessment of barriers to adherence including transportation needs, access to pharmacy, as well as MH or SUD comorbidities.		
Check for drug-drug interactions (including OTC meds)		
Assist with refill monitoring or reminders to prevent gaps in medication supply.		
Provide medication education as needed (side effect counseling, etc)		
OTHER (please check if you need the CCO to support case management in other ways not defined above)		
OR If the member wishes to opt-out, please contact the CCO so that we can assist the member on this process.		
Please send supporting medical records including documentation of all relevant labs & last office visit planning treatment.		
Prescribers signature:		Date:

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