Oregon CAREAssist
Supplemental Form for Hepatitis C Treatment Regimens
TELEPHONE: 888-311-7632 FAX: 800-848-4241

Please complete the appropriate sections below for determination of prior authorization for Hepatitis C therapy

Patient Name_____ Prescribing Physician _____
Last Name First Name

Member ID _____ Prescriber NPI # _____ Specialty_____

DOB_____ Height _____Weight_____ Physician Phone # _____Fax#_____

CD4 count _____ HIV viral load _____ Pharmacy Name_____

Baseline Hepatitis RNA: _____ NABP# _____Contact Person_____

_____ Pharmacy Phone# _____Fax# _____
Signature of pharmacist or physician Date

By signing above, you attest that all statements on this form are true to the best of your knowledge.

All supporting labs and chart documentation are REQUIRED for approval of this request. For Insured patients, pharmacy MUST provide proof of insurance billing through a Primary Insurance Denial Letter AND an Appeal Denial Letter

Does this patient have diagnosis of Chronic Hepatitis C? ☐ Yes ☐ No
What is the Hepatitis C Genotype? (circle one): 1a 1b 2 3 4 5 6

Has this patient been treated for Hepatitis C previously? (check all that apply)

- ☐ None (Treatment naïve)
- ☐ Prior treatment failure to PEG-INF/ribavirin Date:_____
- ☐ Prior treatment failure on telaprevir (Incivek®) or boceprevir (Vitrelis®) Date:_____
- ☐ Other treatment failure:_____ Date:_____

What is the planned treatment regimen and duration? (Please fill in):

- ☐ Drug Name(s) including strength :

  _____

- ☐ Daily Dosing: _____

- ☐ Duration of therapy (weeks): _____

Please confirm the following statements: (check all that apply)

- ☐ This patient is on a stable antiretroviral regimen for HIV with HIV viral load < 200 copies/mL
  List current HIV Therapy_____
- ☐ This patient is an HIV Elite Controller with HIV viral load < 200 copies/mL or long term non-progressor without antiretroviral medication

If the patient has advanced liver disease, please answer the following questions. (Circle)

Does this patient have a history of cirrhosis? YES NO
Does this patient have decompensated liver disease? YES NO

For All

- ☐ I agree to submit HCV RNA result from 4 (or 12) weeks after treatment completion for program evaluation purposes (FAX to Ramsell)
- ☐ I have reviewed the clinical information on the proposed prescription for possible drug-drug interactions with other medications currently prescribed to the patient.

REQUIRED DOCUMENTATION - Please submit ALL required clinical notes/ lab reports in reference to this request. Failure to provide documentation may delay the decision process.

☐ Denial Letter ☐ Appeal denial Letter ☐ Hepatitis C Genotype
☐ Hepatitis C RNA viral load (most recent) ☐ CD4 count (most recent) ☐ HIV viral load (most recent)