

HEPATITIS C THERAPY

Request Form

FAX to 503-416-8109



CareOregon

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503-416-4100 or 800-224-4840
800-735-2900 (TTY/TDD)
www.careoregon.org

* For assistance with urgent requests Monday-Friday 8 a.m.-5 p.m., call CareOregon at 800-224-4840 or 503-416-4100. For assistance after hours, call Express Scripts at 877-526-2313. *

**** All fields must be completed and legible for review ****

<input type="checkbox"/> URGENT REQUEST: By selecting the expedited review and signing this form below, I certify that applying the standard review time frame will seriously jeopardize the life or health of the member or the member's ability to regain maximum function.		
Patient Name:	Prescriber Name and Specialty:	
Member ID #:	NPI#:	
Patient DOB:	Prescriber Office Phone:	Prescriber Office Fax:
Pharmacy Name and Phone:	Prescriber Contact Person:	
Drug Regimen (Including all names, strengths, and frequencies):		
Desired Length of Treatment:	Estimated Start Date of Treatment:	
Is the patient currently receiving HCV treatment?	<input type="checkbox"/> Yes Start Date: _____ <input type="checkbox"/> No	
Does the patient have a history of HCV treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, what was the previous drug regimen and treatment duration?		
Drug Regimen: _____ Treatment Duration: _____		
If Yes, what was the treatment outcome? <input type="checkbox"/> Relapse <input type="checkbox"/> Partial Response <input type="checkbox"/> Null Response <input type="checkbox"/> DC due to adverse event		
Does the patient have co-morbid HBV or HIV?	<input type="checkbox"/> Yes (please circle): HBV HIV <input type="checkbox"/> No	
Patient's HCV Genotype:	Date:	
Liver Biopsy Result (Stage of Fibrosis):	Date:	
Treatment Phase	Quantitative HCV RNA	Date
Pre-Treatment		
4 weeks		
8 weeks		
12 weeks		
Other (Please Specify):		
Does the patient have any of the following? Untreated psychiatric illness, history of liver transplant, decompensated cirrhosis, cytopenia, hemoglobinopathy, ETOH or illicit drug abuse, hyperthyroidism, severe renal impairment, history of renal transplant, autoimmune disease, pregnancy, unstable CVD?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional supporting information:		
Provider Signature		Date

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Please fill out the following **ONLY** if treating genotype 1 with the addition of a protease inhibitor:

Provider Treatment Plan- Please check which of the following your clinic provides; please provide optional details for our internal use:

- Pre-Treatment Education: _____
- Mental Health Screening: _____
- HCV-RNA monitoring...please state frequency _____
- Management of anemia: _____
- Offer tips for the management of minor side effects: _____
- How frequently will the patient be seen or contacted by phone? _____

The CareOregon Hepatitis C CarePathway Program:

Please indicate any resources CareOregon could provide to assist you with this patient's hepatitis C:

- Possible options include providing patient education/counseling on medications, regular patient phone calls to check on their status, offer potential side effect management tips, and depression/mental health screening.
