

HEPATITIS C THERAPY

Request Form

FAX to 503-416-8109



CareOregon

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800-735-2900 (TTY/TDD)
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* 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 #:	DEA#:	
Patient DOB:	Prescriber Office Phone:	Prescriber Office Fax:
Pharmacy Name and Phone:	Prescriber Contact Person:	
Drug Name:		
Dose:	Desired Length 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, why was treatment stopped? <input type="checkbox"/> Relapse <input type="checkbox"/> Failure <input type="checkbox"/> 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 Results:		Date:
Treatment Phase	Quantitative HCV RNA	Date
Pre-Treatment		
4 weeks		
12 weeks		
12-48 weeks or Other		
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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