

# Hepatitis C Treatment Request Form

Patient Information			
Name:			
Date of birth:	CHA ID#	Phone:	
Current address:			
City:	State:	ZIP Code:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height:	Weight:	
Known Allergies:			
Alternate Caregiver Name:			
Provider Information			
Provider Name:			
Provider NPI:	Preferred Clinic Contact:		
Phone:	Fax:		
City, State, Zip			
Diagnosis/Clinical Information		Fax recent notes, labs, tests to 541-883-6104	
ICD-10:	Genotype: <input type="checkbox"/> 1a <input type="checkbox"/> 1b <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	HCV RNA level:	Date (last 6mo):
Fibrosis Score: <input type="checkbox"/> F0 <input type="checkbox"/> F1 <input type="checkbox"/> F2 <input type="checkbox"/> F3 <input type="checkbox"/> F4		Cirrhosis: <input type="checkbox"/> None <input type="checkbox"/> Compensated <input type="checkbox"/> Decompensated	
NS5A Polymorphism: <input type="checkbox"/> Y <input type="checkbox"/> N	NS5A Polymorphism Type : <input type="checkbox"/> 28 <input type="checkbox"/> 30 <input type="checkbox"/> 31 <input type="checkbox"/> 93 <input type="checkbox"/> Other_____	HIV Co-Infection: <input type="checkbox"/>	HBV Co-Infection: <input type="checkbox"/>
Pregnancy Test (past 30 days) : <input type="checkbox"/> Negative <input type="checkbox"/> Positive Date:		Drug/Alcohol Screen: <input type="checkbox"/> Negative <input type="checkbox"/> Positive Date:	
Prior Therapy	End Date	Treatment Weeks	Response Status
			<input type="checkbox"/> Naïve <input type="checkbox"/> Null <input type="checkbox"/> Partial <input type="checkbox"/> Relapse
			<input type="checkbox"/> Naïve <input type="checkbox"/> Null <input type="checkbox"/> Partial <input type="checkbox"/> Relapse
			<input type="checkbox"/> Naïve <input type="checkbox"/> Null <input type="checkbox"/> Partial <input type="checkbox"/> Relapse
Listed for Transplant <input type="checkbox"/> or Post solid organ transplant <input type="checkbox"/>		Will patient and provider comply with all case management and adhere to all monitoring requirements required by the Oregon Health Authority, including measuring and reporting of a post-treatment viral load? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Life Expectancy: <input type="checkbox"/> Greater Than 1 Year <input type="checkbox"/> Less Than 1 Year			
Treatment Requested			
Medication	Dose/Strength	Qty.	Refills
<input type="checkbox"/> Eplclusa (sofosbuvir/velpatasvir)	<input type="checkbox"/> 400mg/100mg	28 day supply	
<input type="checkbox"/> Mavyret (glecaprevir/pibrentasvir)	<input type="checkbox"/> 100mg/40mg	28 day supply	
<input type="checkbox"/> Pegasys (peginterferon alfa-2a)	<input type="checkbox"/> 180mcg <input type="checkbox"/> 135mcg	28 day supply	
<input type="checkbox"/> Ribavirin	<input type="checkbox"/> 200mg	28 day supply	
<input type="checkbox"/> Zepatier (elbasvir/grazoprevir)	<input type="checkbox"/> 50mg/100mg	28 day supply	
<input type="checkbox"/> Vosevi (sofosbuvir/velpatasvir/voxilaprevir)	<input type="checkbox"/> 400mg/100mg/100mg	28 day supply	
<input type="checkbox"/> Other _____			
Provider Signature			
Name:		Date:	

