CHA Hepatitis C Treatment Request Form FAX To: 541-883-6104

Patient Information

Name:		
Date of birth:	CHA ID#	Phone:
Current address:		
City:	State:	ZIP Code:
Gender: ☐ Male ☐ Female	Height:	Weight:
Known Allergies:		
Alternate Caregiver Name:		

Provider Information

Provider Name:	
Provider NPI:	Preferred Clinic Contact:
Phone:	Fax:
Address, City, State, Zip:	

Diagnosis/Clinical Information Fax recent notes, labs, tests to 541-883-6104

ICD-10:	Genotype: ☐1a ☐1b ☐2 ☐3 ☐4 ☐5 ☐6	HCV RNA level:	
Fibrosis Score: ☐F0 ☐F1 ☐F2 ☐F3 ☐F4		Cirrhosis: ☐None ☐Compensated ☐Decompensated	
For Genotype 1: NS5A Polymorphism: ☐Y ☐N	NS5A Polymorphism Type : ☐28 ☐30 ☐31 ☐93 ☐ Other: _____	HIV Co-Infection: ☐ Yes ☐ No	*HBV Co-Infection: ☐ Yes ☐ No **Please return the following Hepatitis B labs: HBsAg; HBsAb; HBcAb**
Pregnancy Test (Past 30 Days) ☐ Negative ☐ Positive Date:			

Prior Therapy	End Date	Treatment Weeks	Response Status
			☐Naïve ☐Null ☐Partial ☐Relapse
			☐Naïve ☐Null ☐Partial ☐Relapse

Listed for Transplant ☐ or Post solid organ transplant ☐	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? ☐ Yes ☐ No
Life Expectancy: ☐ Greater Than 1 Year ☐ Less Than 1 Year	

Treatment Requested

Medication	Dose/Strength	Length of Treatment
☐ Epclusa (sofosbuvir/velpatasvir)	☐ 400mg/100mg	
☐ Mavyret (glecaprevir/pibrentasvir)	☐ 100mg/40mg	
☐ Ribavirin	☐ 200mg	
☐ Vosevi (sofosbuvir/velpatasvir/voxilaprevir)	☐ 400mg/100mg/100mg	
☐Other: _____		

Provider Signature

Name:	Date:

Cascade Health Alliance