CHA Hepatitis C Treatment **Notification**

FAX To: 541-883-6104

(Treatment plan for treatment naïve patients only)

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:			
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			

Provide a summary of case management plan of service that has been discussed and agreed upon with patient:

Treatment Requested		
Medication	Dose/Strength	Length of Treatment
☐ Sofosbuvir-Velpatasvir	☐ 400mg/100mg	☐ 12 weeks
☐ Mavyret (glecaprevir/pibrentasvir)	☐ 100mg/40mg	☐ 8 weeks ☐ 12 weeks

Provider Signature	
Name:	Date:

Cascade Health Alliance