**Hepatitis C Therapy Request Form**

**Please complete and submit via the InTouch Portal along with prior authorization request and supporting documents.**

For assistance, please call our Medicaid Pharmacy Help Desk at (855) 228-6629.

* Available Monday-Friday 8am to 5pm PST

To view our drug policies, please see our **Medicaid Preapproval Criteria** available at [*(https://communitysolutions.pacificsource.com/Search/Drug).*](https://communitysolutions.pacificsource.com/Search/Drug)

**All fields are mandatory, along with submitting clinical documentation that prior authorization criteria has been met.**

|  |
| --- |
| **Patient Information** |
| Patient Name: | Patient ID: |
| Patient DOB: | Pharmacy Name: | Pharmacy Phone: |
| **Prescriber Information** |
| Prescriber Name: | NPI#: |
| Clinic Name: | Office Phone: | Office Fax: |
| Prescriber Contact Person: |
| **Hepatitis C Drugs Requested (include all in regimen, including strength)** | **Frequencies and Duration** |
|  |  |
|  |  |
| Desired Length of Treatment: | Estimated Start Date of Treatment: | Already Started On: |
| **Required Documentation on Case Management*** Our clinic **does offer** the OHA required case management services.
* Our clinic **does NOT offer** the OHA required case management services.
 |
| Oregon Medicaid requires all patients being treated for Hepatitis C be involved in adequate case management to ensure medication compliance and optimal chances for Sustained Virologic Response (SVR) success. The required information includes documentation of:* Attestation of case management protocol or opt-out (see below).
* A care management team, or case manager, is assigned to the patient for the duration of the treatment and will evaluate if additional support is needed.
* Prevent gaps in medication supply and ensure refills are accessed in timely fashion.
* Provide education for patient as needed.
* Initial evaluation of barriers to adherence and plan to address (e.g. transportation, offered MH or SUD treatment, participated in harm reduction and prevention education efforts, etc.).
* Medication reconciliation to assess for drug-drug interactions.
* Reasons for discontinuation of treatment, when applicable.
* SVR 12 weeks post-treatment completion.
 |
| By signing below, I agree if treatment is authorized that our clinic will provide case management to promote the best possible outcome for the patient and adhere to monitoring requirements required by OHA including measuring HCV RNA labs at 12 weeks post-treatment. |
| Prescriber’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Opt-Out Protocol** |
| OHA has consulted with the Department of Justice and has developed the following protocol for the rare occurrence when a patient pursues an opt-out of the case management protocol. Case management is strongly recommended and valuable for the patient to successfully complete treatment; however, patients may opt-out after signing an attestation that they understand:* The goal of case management is to support the client to successfully complete treatment and get required tests performed (prescription coordination, testing, scheduling, and transportation).
* Benefits of participation include:
	+ Coordination with prescriber(s), pharmacy and labs.
	+ Options for education and assistance in accessing care – mental health, SUD, specialist.
	+ Support for adherence.
* Patients will be responsible to schedule, coordinate transportation and to have the required lab tests performed 12 weeks after they finish their prescription.
* Prescriber aware patient has chosen to opt-out.
* Patients may rejoin the case management program at any time.
 |
| By signing below, I have agreed to opt-out of case management services. I understand the goals and benefits of case management and responsibilities associated with treatment, including adherence to treatment and lab tests. |
| Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| PacificSource Community Solutions recommends all prior authorizations be submitted with supporting medical records to help for a faster and more thorough review (include resistance testing if applicable). |