



# HEPATITIS C – SUPPLEMENTAL CLINICAL FORM

THIS FORM MUST BE SUBMITTED WITH ALL REQUESTS FOR HEPATITIS C MEDICATION THERAPY

## 1 PATIENT IDENTIFICATION

|   |  |               |  |                |
|---|--|---------------|--|----------------|
| Last Name   |  | First Name    |  | Middle Initial |
| Date of Birth   | Sex<br>M <input type="checkbox"/> F <input type="checkbox"/> | Medicaid ID # |  |                |
| Does patient have other health insurance providing a pharmacy benefit? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |                |

## 2 PRESCRIBER INFORMATION

|                          |   |            |
|--------------------------|---|------------|
| Prescriber's Name        | NPI Number  | DEA Number |
| Contact Person at Office | Prescriber Specialty<br><input type="checkbox"/> Board Certified Gastroenterology<br><input type="checkbox"/> Board Certified Infectious Disease<br><input type="checkbox"/> Other: _____<br>If therapy recommended by Specialist, please attach consult note. Attached: YES <input type="checkbox"/> NO <input type="checkbox"/> |            |
| Telephone Number         |   |            |
| Fax Number               |   |            |

## 3 PATIENT CLINICAL INFORMATION (PART 1)

Diagnosis: Hepatitis C YES  NO  Date of Initial Diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_

Genotype: 1  2  3  4  5  6

If Genotype 1: Genotype 1a YES  NO

If Yes and Prescribing Olysio®: Q80K Polymorphism YES  NO  N/A

Fibrosis Score: 0  1  2  3  4  Unknown

Decompensated Liver Disease: YES  NO

Hepatocellular carcinoma & awaiting liver transplant YES  NO

Status post-liver transplant YES  NO

### Fax Completed Form to:

Fax Number: 800-218-3221

Phone Number: 866-843-3604



4

## PATIENT CLINICAL INFORMATION (PART 2)

Patient is: Treatment Naive  Has received Prior Therapy

If Prior Therapy: Relapser  Partial Responder  Null Responder  New Infection

Prior regimen: \_\_\_\_\_

Dates of Prior Therapy/Duration: \_\_\_\_\_

Did Patient Complete Planned Therapy: YES  NO

If No, Reason for Non-Completion: Adverse Reaction  Did Not Meet RGT Criteria

Lost to Follow-Up  Other  Please explain: \_\_\_\_\_

HIV + YES  NO

Is Patient IFN ineligible: YES  NO

If YES, reason: \_\_\_\_\_

Does patient have a history of alcohol abuse: YES  NO

If YES, date of last alcoholic drink: \_\_\_\_/\_\_\_\_/\_\_\_\_

If YES, is patient currently enrolled in an alcohol support program: YES  NO

If YES, how is this independently verified: \_\_\_\_\_

Does patient have a history of substance abuse: YES  NO

If YES, clean date: \_\_\_\_/\_\_\_\_/\_\_\_\_

If YES, is patient currently enrolled in a substance use program: YES  NO

If YES, how is this independently verified: \_\_\_\_\_

Has the patient been educated to the possible side effects of therapy: YES  NO

Proposed Therapy (complete Hepatitis Medication Order Form)

Attached: YES  NO

Rate the Likelihood of Patient Completing the Proposed Therapy:

High  Moderate  Indeterminate

Pertinent Extenuating Circumstances (explain): \_\_\_\_\_

5

### NB: Recent Clinical Note Must be Attached for PA Consideration

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_