



HEPATITIS C – SUPPLEMENTAL CLINICAL FORM

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

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PATIENT IDENTIFICATION

Last Name		First Name	Middle Initial
Date of Birth	Sex 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"/>			

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PRESCRIBER INFORMATION

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

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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 ☎

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PATIENT CLINICAL INFORMATION (PART 2)

Patient is: **Treatment Naïve** **Has received Prior Therapy**

If Prior Therapy: Relapser Partial Responder Null Responder

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): _____

NB: Recent Clinical Note Must be Attached for PA Consideration

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Prescriber's Signature: _____ **Date:** _____