



# UMPQUA HEALTH

ALLIANCE

500 SE CASS AVENUE, SUITE 200  
ROSEBURG, OR 97470

For assistance with this form, you may call UHA at 541.673.1462  
To view our drug policies, please review OHA's [Prior Auth Criteria](#).

**\*\*All fields are mandatory and failure to complete will result in the requesting being canceled\*\***

Patient Name:	Prescriber Name:
Member ID #:	Prescriber NPI #:
Patient DOB:	Clinic Name:
Pharmacy Name:	Office #: <span style="float: right;">Fax#</span>
Pharmacy Phone:	Prescriber Contact Person:
Hepatitis C Drug Requested:	Treatment Length:

### Past Treatment History

Dose the patient have a history of HCV treatment?  No  Yes Drug Regimen:  
 If past treatment failed, was adherence with medication a concern?  Yes  No  Not sure

Patient's HCV Genotype (drawn <3 years):	HCV RNA Quant (drawn <6 months):	Date:
---	----------------------------------	-------

Does the patient have HIV?  No  Yes Does the patient have Hepatitis B?  No  Yes

Other Extra Hepatitic Manifestations?

Stage of Fibrosis and method of testing (ie Biopsy, Fibroscan, Fibrosure, Fibrospect, Clinical Diagnosis):	Date:
--	-------

Child-Pugh Score:  1  2  3  4  
 Cirrhosis Status:  Compensated  Decompensated  Non-Cirrhotic

Related to Liver Transplant?  NO  Yes Expected survival from non-HCV associated morbidities more than one 1 year?  NO  Yes

**Case Management:** Oregon Medicaid requires all members being treated for Hepatitis C to be involved in adequate case management to ensure medication compliance and optimal chances for SVR success. Does your patient agree to be followed by Umpqua Health Alliance Case Management?  No  Yes

**\*\* Umpqua Health Alliance recommends all prior authorizations to be submitted with supporting medical records for a faster and more thorough review.\*\***