PacificSource Community Solutions
PO Box 5729, Bend, OR 97708-5729
800.431.4135
CommunitySolutions.PacificSource.com

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).*

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

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.
- ☐ Adequate access to prescribers and treatment without unreasonable delay.
- ☐ 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.).
- ☐ Genotype (if known).

- ☐ Cirrhosis status.
- ☐ Treatment regimen.
- ☐ Medication Reconciliation to assess for drug-drug interactions.
- ☐ Contact the patient prior to initiating treatment and as frequently as needed to ensure compliance, access to refills, and collection of 12 week SVR.
- ☐ The date treatment began (by date dispensed) and an explanation for treatment start dates greater than 30 days following approval.
- ☐ Warm hand-off documented in case of eligibility/enrollment changes (churn).
- ☐ Appropriate billing (e.g. churn or switch to TPL, quantity and NDC included on medical claims).
- ☐ Reasons for discontinuation of treatment, when applicable.
- ☐ Previous HCV treatment status and regimen used, when applicable.
- ☐ SVR 12 weeks post treatment completion.
- ☐ Transition to complex or chronic illness case management if needed.

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.

☐ Our clinic **does offer** the OHA required case management services.

☐ Our clinic **does NOT offer** the OHA required case management services.

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).

By signing below, I agree if treatment is authorized that our clinic will provide data elements as required by the Oregon Health Authority (OHA) including notifying the plan of the ultimate result of therapy including HCV RNA labs at 12 weeks post-treatment.

Prescriber's Signature: _____ Date: _____

By signing below, I agree if treatment is authorized that I will participate in all case management elements as listed above as required by the Oregon Health Authority (OHA) including returning to my clinic 12 weeks after completing my treatment to complete lab-work.

Patient's Signature: _____ Date: _____