SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Hepatitis C Therapy Continuation Prior Authorization Form

Member Name: _____ ***Date of Birth:***_____ ***Member ID#:***_____
Pharmacy Name:_____ ***Pharmacy NPI:***_____
Pharmacy Phone: _____ ***Pharmacy Fax:***_____
Pharmacist Name:_____ ***Prescriber Name:*** _____
Prescriber NPI: _____ ***Specialty:***_____
Prescriber Phone:_____ ***Prescriber Fax:*** _____

Pharmacy Section

Member's Hepatitis C Therapy Regimen:_____

_____

Drug Name:_____ ***NDC:***_____

Today's Date:_____ ***Date Prescription Last Filled:***_____

Date Member Took First Dose:_____ ***Expected End Date:***_____

Number of doses remaining today: _____ ***Refill Number:***_____

Did the member fill ribavirin? Yes____ No_____

Date ribavirin last filled: _____ ***Remaining Supply:***_____

Pharmacist Signature: _____ **Date:** _____

Prescriber Section

Initial Viral Load_____ ***Date Tested:*** _____

Recent Viral Load_____ ***Date Tested:*** _____

Recent Urine Drug Screen? Yes____ No____ Date Tested: _____

Monthly Pregnancy Test?** Yes____ No____ NA____ Date Tested: _____

***Required for female members and female partners of male members.*

Has the member experience any adverse drug reactions related to hepatitis C therapy?

Yes____ No____

If yes, please specify reactions: _____

_____

Prescriber Signature: _____ **Date:** _____

Please do not send in chart notes. Specific information/documentation will be requested if necessary.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

CONFIDENTIALITY NOTICE