

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

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