



Advanced Health
289 LaClair St, Coos Bay, OR 97420
 Voice: 541-269-7400 • 800-264-0014
 Fax: 541-269-7147 • TTY: 877-769-7400

HepC Care & Readiness to Treat Checklist

Provider Information:

Provider: _____ Provider Phone #: _____

Patient Information:

Patient Name: _____ Date of Birth: ____/____/____

Address: _____ Phone #: _____

Waiver of Information:

Patient must sign the release of information below.

I understand that this form will be forwarded to Advanced Health, my Oregon Health Plan Coordinated Care Organization. The information provided will be used to contact me so that I may be enrolled in HepC Care Management and receive information regarding available health care services. I also agree to any labwork required by the Oregon Health Authority.

Patient signature: _____ Date: ____/____/____

To establish your patient with HCV Care Management for treatment, please submit the Medicaid Authorization Form, the MedImpact Form, the prescription, and the following information to: Kristien Van Elsberg via fax 541-269-7147

(Please attach all labs for the below items)**

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| <p><u>Required Labs:</u></p> <p>CBC CMP w/hepatic function panel</p> <p>PT/INR HBsAG</p> <p>HbsAb HBCAB</p> <p>HIV Testing(within 1 year)</p> <p>Iron Studies(within 6 mos)</p> <p>HCV/RNA</p> <p>Genotype (within 3yrs)</p> <p>Pregnancy Test within 30 days (50 yrs and younger)</p> <p>Fibrosis Score(if available)</p> <p>Abdominal Imaging (rule out ascites & cirrhosis)</p> | <p><u>Other:</u></p> <p>Child Pugh Score: _____</p> <p>Current chart note</p> <p>Completed Medication Authorization Form</p> <p>Completed MedImpact Form</p> <p><u>Immunizations:</u></p> <p>Hep A Hep B</p> |
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For questions, contact Kristien Van Elsberg @ 541-266-6504 or @ kristien.vanelsberg@advancedhealth.com

Additional Information:

Is the patient on Advanced Health: YES NO If Yes, enter Advanced Health/OHP#: _____

Has patient previously been treated for HepC? YES NO

If Yes, what treatment did they receive? _____

Did they complete the treatment? YES NO

If No, please provide information detailing why treatment was not completed (medication side effects, non-adherence, etc.)

Does the patient have complications of cirrhosis (ascites, portal hypertension, hepatic encephalopathy, hepatocellular carcinoma, esophageal varices)? YES NO

If YES, has the patient established care with or in consultation with a hepatologist, gastroenterologist, or infectious disease specialist? YES NO

If YES, who? _____

Is expected survival from non-HCV associated morbidities more than 1 year? YES NO

Contact Kristien Van Elsberg @ 541-266-6504 or @ kristien.vanelsberg@advancedhealth.com