AdvancedHealth
Bridging the Future of Healthcare
Coordinated Care Organization
Phone: 541-269-7400 Fax: 541-269-7147

Hepatitis C Readiness to Refer Tool

****Both sides of form must be completed****

The Hepatitis C Readiness to Refer Tool should be **used for asymptomatic** adult patients considering treatment of chronic Hepatitis C Virus (HCV). This completed tool must be submitted with referral requests for out of area gastroenterology or hepatology services for asymptomatic patients. **This tool does not apply to symptomatic patients**. (Example symptoms include: jaundice, ascites, hepatic encephalopathy, portal hypertension etc.) If patient is symptomatic, please submit referral for out of area GI / Hepatology with chart notes supporting symptoms and need for referral.

Member Name: _____

Member OHP ID#: _____

Member DOB: ____/____/____

If patient does not meet all the criteria listed on the back page of this form, HCV treatment is not recommended at this time. Please develop a care plan to begin assisting the patient in resolving any identified risk factors as appropriate. The patient may be referred to the appropriate community resources listed below when applicable.

- ADAPT: (541) 751-0357
- Coos Health and Wellness: (541) 751-2500
- Curry Community Health: (541) 373-8001
- Advantage Dental: (866) 268-9631
- Advanced Health: (541) 269-7400
- Bay Cities Brokerage: (541) 266-4323

If the patient does not have any risk factors for treatment of HCV, please submit a copy of this completed evaluation with your prior authorization referral request form for consideration. If you have questions, please contact Advanced Health at (541) 269-7400.

Please note a separate prior authorization request for medications to treat HCV will be required and patient must meet established drug use criteria for coverage. Twelve months of PCP notes, drug screens and other criteria as outlined on the back page of this form, and all specialist's notes pertaining to the treatment request will be required. Additional documentation from other providers may be required.

Additional Information or Comments:

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Member Name:_____ DOB: ____/____/____

For Prior authorization request to GI specialist for Hep C treatment; please submit the following with supporting documentation and the Prior Authorization form to 541-269-7147.

☐Yes ☐No **1.** Member agrees to participate in the Advanced Health Hep C Care Management Program.

☐Yes ☐No **2.** Immunizations: Hep A, Hep B, Pneumococcal, and Influenza

☐Yes ☐No **3.** Routine labs of CBC, CMP with Hepatic function panel, PT / INR, HBsAG, HbsAb, HBcAB, HIV testing, and Iron studies (within 6 months and pregnancy test within 30 days, if female and younger than 50 years of age). Results attached.

☐Yes ☐No **4.** The patient has been screened for depression and is receiving treatment if appropriate. Untreated mental health conditions are risk factors to successful HCV treatment and must be stabilized prior to consideration of HCV treatment.

☐Yes ☐No **5.** Screen the patient for use of drugs and alcohol, refer to Adapt if appropriate (DAST, AUDIT and a urine drug screen required). DAS 11 or similar test which includes alcohol metabolites will be required for all patients. Results attached. http://www.sbirtoregon.org/

☐Yes ☐No **6.** Documented screening for tobacco use and counselled to quit smoking, if applicable. Quit Date has been documented. (Nicotine Patches, Gum and Lozenges available on formulary).

☐Yes ☐No **7.** Life expectancy greater than one year documented and patient does **NOT** have a new diagnosis or relevant procedure expected to alter or impact life expectancy (e.g. end stage renal / liver disease, cancer, etc.).

☐Yes ☐No **8.** Viral load within 6 months and genotype within 3 years. Results attached.

☐Yes ☐No **9.** Fibrosis score of F2, F3 or F4 on liver biopsy, elastography/fibroscan, Fibrospect II, or clinical evidence of cirrhosis. Results attached. (Liver Biopsy or Fibroscan are preferred measurements).

☐Yes ☐No **10.** Patient is up to date on recommended screenings as appropriate: Colonoscopy, mammogram, preventative care, hepatocellular carcinoma screening, etc.

If patient has Fibrosis Score of F2 and PCP is prescribing treatment for Chronic Hepatitis C Virus; in addition to the information above, please also submit the following to Advanced Health Hep C Care Management prior to request for treatment. Fax all information to 541-269-7147 attention: Hep C Care Management.

1. Treatment medication to be prescribed>

Hepatitis C Direct-Acting Antivirals

2. Treatment plan schedule including follow ups, labs and viral load testing.

3. NSA5 Resistance testing; if appropriate.

I attest to the above information being accurate to the best of my medical knowledge and expertise.
I understand that additional documentation to support the above items may be requested.

Provider Signature: _____ Date: _____

(Rev 3/14/18)