Advanced Health
289 LaClair St, Coos Bay, OR 97420
Voice: 541-269-7400 • 800-264-0014
Fax: 541-269-7147
TTY: 711 or 800-735-1232

HepC Care & Readiness to Treat Checklist

***If treatment naive, no authorization or care management requirement.
If treatment experienced, authorization and care management are both required.

Provider Information:

Provider: ____ Provider Phone #: ___________________________

Patient Information:

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

Address: ____ Phone #: __________________________________

Additional Information:

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

Please submit the following information to: Kristien Van Elsberg via fax 541-269-7147

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

Required Labs:

- ☐ HCV/RNA
- ☐ HIV Testing (within 1 year)
- ☐ Genotype (within 3 yrs)
- ☐ HbsAb (to be drawn within 6 mos)
- ☐ HBsAG (to be drawn within 6 mos)
- ☐ HBcAB (to be drawn within 6 mos)

Other:

- ☐ Current chart note
- ☐ Authorization Form

☐ Please indicate if you would like for your patient to receive **Care Management** through this treatment.

Has patient previously been treated for HepC? YES ☐ NO ☐

If Yes, what treatment did they receive?____

If Yes, please complete / submit the Medication Authorization form.

Did they complete the treatment? YES ☐ NO ☐

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

For questions, contact Kristien Van Elsberg @ 541-266-6504 or @ kristien.vanelsberg@advancedhealth.com

(Rev 2/2023)