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:***_____

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

*Do **NOT** estimate doses on hand

Did the member fill ribavirin? Yes ☐ ***No*** ☐

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

Pharmacist Signature: _____ **Date:** _____

By signature, the pharmacist confirms the above information is accurate.
Please do not send in chart notes. Specific information/documentation will be requested if necessary.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
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	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*