



# Hepatitis C Enrollment Form

Specialty Pharmacy Enrollment Form

Please detach before submitting to a pharmacy – tear here.

## PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name \_\_\_\_\_

DOB \_\_\_\_\_ Last Four of SS# \_\_\_\_\_ Gender \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Language Preference:  English  Spanish  Other \_\_\_\_\_

## PRESCRIBER INFORMATION

Prescriber's Name \_\_\_\_\_

DEA \_\_\_\_\_ NPI \_\_\_\_\_

Group/Hospital \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

## INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number \_\_\_\_\_

## MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

B18.2 Chronic Hepatitis C  K72.90 Hepatic failure, unspecified without coma  C22.0 Liver Cell Carcinoma

Other Diagnosis: ICD-10 Code \_\_\_\_\_ Description \_\_\_\_\_

Genotype \_\_\_\_\_ Viral Load \_\_\_\_\_ IU/ml Viral Load Date \_\_\_\_\_ HIV Coinfected:  Yes  No HBV Coinfected:  Yes  No

Previous therapy history: Naïve \_\_\_\_\_ Relapsed \_\_\_\_\_ Partial Responder \_\_\_\_\_ Null \_\_\_\_\_

Date(s) of previous therapy and meds \_\_\_\_\_

Cirrhosis:  Yes  No  Compensated OR  Decompensated Fibrosis Score \_\_\_\_\_

Liver Transplant:  Yes  No Waiting for Liver Transplant:  Yes  No

Please include hard copies of: genotype, viral load, liver biopsy scans, CBC, CMP, HIV, PT/INR, H&P, NS5A resistance testing and pertinent office visit notes.

## PRESCRIPTION INFORMATION

**EPCLUSA** (sofosbuvir 400mg/velpatasvir 100mg) disp. 28 Sig: 1 tablet daily Refill: x \_\_\_\_\_ Total duration of therapy \_\_\_\_\_ Weeks

**HARVONI**® (ledipasvir 90mg/sofosbuvir 400mg) disp. 28 Sig: 1 tablet daily Refill: x \_\_\_\_\_ Total duration of therapy \_\_\_\_\_ Weeks

**MAVYRET**™ (glecaprevir 100mg/pibrentasvir 40mg) disp 84 Refill: x \_\_\_\_\_ Total duration of therapy \_\_\_\_\_ Weeks  
Sig: Take 3 tablets (contents of one daily dose card) by mouth once daily with food.

### RIBAVIRIN 200mg:

Directions \_\_\_\_\_

Quantity \_\_\_\_\_

Refill: x \_\_\_\_\_ Total duration of therapy \_\_\_\_\_ Weeks

< 75kg = 1000mg/day

≥ 75kg = 1200mg/day

### RIBAPAK (28 day supply):

1200mg daily/600mg QAM—600mg QPM

1000mg daily/600mg QAM—400mg QPM

800mg daily/400mg QAM—400mg QPM

600mg daily/200mg QAM—400mg QPM

Refill: x \_\_\_\_\_ Total duration of therapy \_\_\_\_\_ Weeks

### MODERIBA (28 day supply):

1200mg daily/600mg QAM—600mg QPM

1000mg daily/600mg QAM—400mg QPM

800mg daily/400mg QAM—400mg QPM

600mg daily/200mg QAM—400mg QPM

Refill: x \_\_\_\_\_ Total duration of therapy \_\_\_\_\_ Weeks

**SOVALDI**™ (sofosbuvir) 400mg disp. 28 Sig: 400mg daily Refill: x \_\_\_\_\_ Total duration of therapy \_\_\_\_\_ Weeks

**VOSEVI** Disp. 28 day supply Sig: Take once daily with food Refill: x \_\_\_\_\_ Total duration of therapy \_\_\_\_\_ Weeks

**ZEPATIER** (elbasvir 50mg/grazoprevir 100mg) disp. 28 Refill: x \_\_\_\_\_ duration of therapy \_\_\_\_\_ Weeks  
Sig: Take 1 tablet daily with or without food.  NS5A resistance testing included

**Supportive Therapy:**  **PROMACTA**® PO QD  12.5mg tablets  25mg tablets  50mg tablets  75mg tablets  100mg tablets

Quantity \_\_\_\_\_ Refill: x \_\_\_\_\_ Total duration of therapy \_\_\_\_\_ Weeks **\*Titrate based on platelet count not to exceed 100mg PO QD**

**\*Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to:  Patient  Office First Fill (future fills to Patient)  Office ALL fills  Other \_\_\_\_\_ Date \_\_\_\_\_ Needs by Date \_\_\_\_\_

Product Substitution permitted  Dispense as Written

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_ Supervising Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Electronic or digital signatures not accepted.

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.