Hepatitis C

Select Location

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DATE: _____ **NEEDS BY DATE:** _____ **SHIP TO:** ❑ PATIENT ❑ OFFICE - FIRST DOSE ❑ OFFICE - ALL DOSES ❑ OTHER _____

PATIENT INFORMATION

Patient Name		
Address		
City	State	Zip
Main Phone	Alternative Phone	Date of Birth
Social Security #	Sex ❑ Male ❑ Female ❑ other:	
Gender Identity ❑ Male ❑ Female ❑ Transgender ❑ other:		

PRESCRIBER INFORMATION

Prescriber Name		
Prescriber Type ❑ Physician (MD or DO) ❑ Nurse Practitioner ❑ Physician's Assistant		
Supervising Physician (If prescriber is a NP or PA)		
DEA #	NPI #	Tax ID #
Address		
City	State	Zip
Phone	Fax	
Contact Person	Preferred Method of Contact ❑ Phone ❑ Fax ❑ Email	

INSURANCE: PLEASE FAX BOTH SIDES OF PRESCRIPTION CARD AND MEDICAL CARD(S)

CLINICAL INFORMATION

Diagnosis / ICD10: ❑ B18.2 Chronic Hepatitis C ❑ B17.10 Acute Hepatitis C ❑ Z94.4 Liver Transplant ❑ B20 HIV ❑ HBV ❑ Other:		DX Code:
Genotype: ❑ 1a (❑ NS5A RAVs) ❑ 1b ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6	Responder Status: ❑ Naïve ❑ Relapsed ❑ Partial Responder ❑ Non-Responder	
Patient Height	Patient Weight	Patient Allergies
Previous Therapy	Dates of Therapy	
Viral Load	Load Date	
Fibrosis Stage ❑ F0 ❑ F1 ❑ F2 ❑ F3 ❑ F4	❑ Cirrhosis ❑ Decompensated ❑ Liver Transplant Candidate ❑ Solid Organ Transplant Recipient	

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By submitting this form, you are authorizing the pharmacy and its representatives to act on your behalf to obtain prior authorizations for the prescribed medication(s). We will also pursue available copay and financial assistance on behalf of your patients when available.
The pharmacy can only accept faxed prescriptions directly from a prescriber's office.

PATIENT INFORMATION		
Patient Name	Date of Birth	Prescription Date

PRESCRIPTION INFORMATION			DURATION	QTY	REFILLS
❑ Daklinza™ (daclatasvir)	❑ 30mg Tablet ❑ 60mg Tablet	Take _____ mg PO QD with or without food *administer with sofosbuvir*	_____ Weeks	4 Week Supply	_____
❑ Epclusa®	400mg / 100mg Tablet (sofosbuvir/velpatasvir)	Take one tablet PO QD with or without food	_____ Weeks	4 Week Supply	_____
❑ Harvoni®	90mg / 400mg Tablet (ledipisvir/sofosbuvir)	Take one tablet PO QD with or without food	_____ Weeks	4 Week Supply	_____
❑ Mavyret™	100mg / 40mg Tablet (glecaprevir/pibrentasvir)	Take three tablets PO QD with food	_____ Weeks	4 Week Supply	_____
❑ Sovaldi®	400mg Tablet (sofosbuvir)	Take one tablet PO QD with or without food	_____ Weeks	4 Week Supply	_____
❑ Vosevi™	400mg / 100mg / 100mg Tablet (sofosbuvir/velpatasvir/voxilaprevir)	Take one tablet PO QD with food	_____ Weeks	4 Week Supply	_____
❑ Zepatier™	50mg / 100mg Tablet (elbasvir/grazoprevir)	Take one tablet PO QD with or without food	_____ Weeks	4 Week Supply	_____
❑ Ribavirin	❑ 200mg tablets ❑ 200mg capsules ❑ 200mg Moderiba ❑ Moderiba Dose Pack ❑ Ribapak	❑ 1200mg: 600mg PO QAM, 600mg PO QPM ❑ 1000mg: 600mg PO QAM, 400mg PO QPM ❑ 800mg: 400mg PO QAM, 400mg PO QPM ❑ 600mg: 400mg PO QAM, 200mg PO QPM ❑ Other: _____ mg: take _____ PO QAM & _____ PO QPM	_____ Weeks	4 Week Supply	_____
❑ Riba-Pak®	❑ 600/600mg ❑ 600/400mg ❑ 400/400mg ❑ 200/400mg	_____ mg: take _____ mg PO QAM & _____ PO QPM	_____ Weeks	4 Week Supply	_____
❑ Other		_____	_____ Weeks	_____	_____

In order to expedite the prior authorization process, please fax copies of the patient's most recent progress notes and lab work. Please include: CBC, Chemistry, HCV Viral Load, HCV Genotype, Fibrosis Score.
For Medicaid patients, include Drug and Alcohol Screenings (within 30 days.)

Dispense As Written (no stamps) | **Date** | **Substitution Permitted** (no stamps) | **Date**

In order for a brand name product to be dispensed, the prescriber must write "Brand Necessary" or "Brand Medically Necessary" or any required state-specific language.
The pharmacy can only accept faxed prescriptions directly from a prescriber's office.
Prescribers must comply with any of their state-specific prescription requirements.