

Hepatitis C



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 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> other:	
Gender Identity <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> other:		

PRESCRIBER INFORMATION		
Prescriber Name		
Prescriber Type	<input type="checkbox"/> Physician (MD or DO)	<input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> 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 <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email	

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

CLINICAL INFORMATION		
Diagnosis / ICD10: <input type="checkbox"/> B18.2 Chronic Hepatitis C <input type="checkbox"/> B17.10 Acute Hepatitis C <input type="checkbox"/> Z94.4 Liver Transplant <input type="checkbox"/> B20 HIV <input type="checkbox"/> HBV <input type="checkbox"/> Other:		DX Code:
Genotype: <input type="checkbox"/> 1a (<input type="checkbox"/> NSSA RAVs) <input type="checkbox"/> 1b <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	Responder Status: <input type="checkbox"/> Naïve <input type="checkbox"/> Relapsed <input type="checkbox"/> Partial Responder <input type="checkbox"/> Non-Responder	
Patient Height	Patient Weight	Patient Allergies
Previous Therapy	Dates of Therapy	
Viral Load	Load Date	
Fibrosis Stage <input type="checkbox"/> F0 <input type="checkbox"/> F1 <input type="checkbox"/> F2 <input type="checkbox"/> F3 <input type="checkbox"/> F4	<input type="checkbox"/> Cirrhosis <input type="checkbox"/> Decompensated	<input type="checkbox"/> Liver Transplant Candidate <input type="checkbox"/> 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
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PRESCRIPTION INFORMATION			DURATION	QTY	REFILLS
<input type="checkbox"/> Daklinza™ (daclatasvir)	<input type="checkbox"/> 30mg Tablet <input type="checkbox"/> 60mg Tablet	Take _____ mg PO QD with or without food <i>administer with sofosbuvir</i>	_____ Weeks	4 Week Supply	_____
<input type="checkbox"/> Epclusa®	400mg / 100mg Tablet (sofosbuvir/velpatasvir)	Take one tablet PO QD with or without food	_____ Weeks	4 Week Supply	_____
<input type="checkbox"/> Harvoni®	90mg / 400mg Tablet (ledipasvir/sofosbuvir)	Take one tablet PO QD with or without food	_____ Weeks	4 Week Supply	_____
<input type="checkbox"/> Mavyret™	100mg / 40mg Tablet (glecaprevir/pibrentasvir)	Take three tablets PO QD with food	_____ Weeks	4 Week Supply	_____
<input type="checkbox"/> Sovaldi®	400mg Tablet (sofosbuvir)	Take one tablet PO QD with or without food	_____ Weeks	4 Week Supply	_____
<input type="checkbox"/> Vosevi™	400mg / 100mg / 100mg Tablet (sofosbuvir/velpatasvir/voxilaprevir)	Take one tablet PO QD with food	_____ Weeks	4 Week Supply	_____
<input type="checkbox"/> Zepatier™	50mg / 100mg Tablet (elbasvir/grazoprevir)	Take one tablet PO QD with or without food	_____ Weeks	4 Week Supply	_____
<input type="checkbox"/> Ribavirin	<input type="checkbox"/> 200mg tablets <input type="checkbox"/> 200mg capsules <input type="checkbox"/> 200mg Moderiba <input type="checkbox"/> Moderiba Dose Pack <input type="checkbox"/> Ribapak	<input type="checkbox"/> 1200mg: 600mg PO QAM, 600mg PO QPM <input type="checkbox"/> 1000mg: 600mg PO QAM, 400mg PO QPM <input type="checkbox"/> 800mg: 400mg PO QAM, 400mg PO QPM <input type="checkbox"/> 600mg: 400mg PO QAM, 200mg PO QPM <input type="checkbox"/> Other: _____ mg: take _____ PO QAM & _____ PO QPM	_____ Weeks	4 Week Supply	_____
<input type="checkbox"/> Riba-Pak®	<input type="checkbox"/> 600/600mg <input type="checkbox"/> 600/400mg <input type="checkbox"/> 400/400mg <input type="checkbox"/> 200/400mg	_____ mg: take _____ mg PO QAM & _____ PO QPM	_____ Weeks	4 Week Supply	_____
<input type="checkbox"/> 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
<small>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.</small>			