Hepatitis C Enrollment Form (A-S)

PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____ / _____ / _____ ☐ Male ☐ Female
SSN: _____ - _____ - _____
Address: _____
City: _____ State: _____ Zip: _____

Phone: (_____) - _____ - _____
Email: _____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: _____ / _____ / _____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____ Clinic/Hospital Affiliation: _____

Phone: (_____) - _____ - _____ Fax: (_____) - _____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

HEPCASRX-19-01

CLINICAL CONSIDERATIONS

Diagnosis: ☐ B18.2 HCV (Chronic) ☐ Other: _____
Coinfections: ☐ HIV ☐ HEPB
Previously treated for HCV: ☐ Yes ☐ No
If Yes: ☐ Non-responder ☐ Partial-responder
☐ Relapser ☐ Incomplete
Previous therapy: _____ Date: ____ /____ / ____
History of Drug/Alcohol Use: ☐ Yes ☐ No
If Yes, abstinence for at least 3 months?: ☐ Yes ☐ No

Genotype: ☐ 1a ☐ 1b ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
Viral Load: _____ Date: ____ /____ / ____
Cirrhosis: ☐ Decompensated ☐ Compensated ☐ None
Liver Biopsy: ☐ Yes ☐ No
Degree of fibrosis: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4

Immunization History
☐ Influenza
Date: ____ /____ / ____

℞

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Daklinza®** (daclatasvir)	☐ 90 mg ☐ 60 mg ☐ 30 mg	☐ Take one tablet by mouth daily with or without food in combination with Sovaldi®	28-day supply	
☐ **Epclusa®** (velpatasvir/sofosbuvir)	☐ 400 mg / 100 mg	☐ Take one tablet by mouth daily with or without food	28-day supply	
☐ **Harvoni®** (ledipasvir/sofosbuvir)	☐ 90 mg / 400 mg ☐ 45 mg / 200 mg	☐ Take one tablet by mouth daily with or without food	28-day supply	
☐ **Mavyret®** (glecaprevir/pibrentasvir)	☐ 100 mg / 40 mg	☐ Take 3 tablets by mouth daily with food	28-day supply	
☐ **Ribasphere RibaPak®** ☐ **Moderiba®** (ribavirin)	☐ **600 mg** (200 mg QAM / 400 mg QPM) ☐ **800 mg** (400 mg QAM / 400 mg QPM)	☐ **1000 mg** (600 mg QAM / 400 mg QPM) ☐ **1200 mg** (600 mg QAM / 600 mg QPM)		
☐ **Sovaldi®** (sofosbuvir)	☐ 200 mg ☐ 400 mg	☐ Take one tablet by mouth daily with or without food	28-day supply	

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: _____ / _____ / _____