Hepatitis C Enrollment Form (T-Z)

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 #: _____

HEPCTZRX-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
☐ **Viekira Pak®** (dasabuvir/ombitasvir /paritaprevir/ritonavir)	☐ 12.5 mg / 75 mg / 50 mg / 250 mg	☐ Take 2 ombitasvir, paritaprevir, ritonavir (pink) tablets once daily (in the morning) and 1 dasabuvir (beige) tablet twice daily (morning and evening) with a meal	28-day supply	
☐ **Vosevi®** (sofosbuvir/velpatasvir/ voxilaprevir)	☐ 400 mg / 100 mg / 100 mg	☐ Take one tablet by mouth daily with food	28-day supply	
☐ **Zepatier®** (elbasvir/grazoprevir)	☐ 50 mg/100 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: ____ / ____ / ____