

# 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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**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.)

<b>Dispense As Written</b> (no stamps)	<b>Date</b>	<b>Substitution Permitted</b> (no stamps)	<b>Date</b>
<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>			