

Hepatitis C

Patient Information				
Patient Name:		Date of Birth:		<input type="checkbox"/> Male <input type="checkbox"/> Female
Address:		City:	State:	Zip:
Phone Number:	Alternate Phone Number:		Language:	
Social Security Number:		E-Mail:		
Allergies (REQUIRED):				<input type="checkbox"/> NKDA
<input type="checkbox"/> Pick Up / Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Office <input type="checkbox"/> Alternative Address:				
Insurance/Prescription Benefits: Please fax copy of insurance card (front and back) and prescription benefits (RxBin, RxGrp, PCN, ID)				
Prescriber Information				
Practice Name:		Office Contact:		
Prescriber:		NPI:	DEA:	
Practice Address:		City:	State:	Zip:
Phone Number:		Fax Number:		
Clinical Notes: Please send last 3 available chart notes and lab results with order				
Clinical Information				
ICD-10/Diagnosis: <input type="checkbox"/> B18.2 (Chronic HCV) <input type="checkbox"/> Other:		Patient type: <input type="checkbox"/> naïve <input type="checkbox"/> relapse <input type="checkbox"/> partial responder <input type="checkbox"/> null responder		
Co-Infections: <input type="checkbox"/> None <input type="checkbox"/> HIV <input type="checkbox"/> Hepatitis B		Prior Failed Therapy:		
Is there cirrhosis? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is it <input type="checkbox"/> compensated <input type="checkbox"/> decompensated		Metavir score: <input type="checkbox"/> F0 <input type="checkbox"/> F0-F1 <input type="checkbox"/> F1 <input type="checkbox"/> F1-F2 <input type="checkbox"/> F2 <input type="checkbox"/> F2-F3 <input type="checkbox"/> F3 <input type="checkbox"/> F3-F4 <input type="checkbox"/> F4 Activity: <input type="checkbox"/> A1 <input type="checkbox"/> A2 <input type="checkbox"/> A3 <input type="checkbox"/> A4	Child Pugh Score (if cirrhosis): <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C eGFR: _____ mL./min/1.73m ²	
Genotype/Subtype: <input type="checkbox"/> 1a <input type="checkbox"/> 1b <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> Unknown For Olysio® order, is the Q80K polymorphism present? <input type="checkbox"/> Yes <input type="checkbox"/> No		Baseline viral load (UI/mL): Baseline viral load (Log UI/mL):	Is the patient interferon intolerant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Fibroscan™ (kPa):	FibroSURE®:	Is the patient awaiting liver transplant for hepatocellular carcinoma? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Prescription Information				
Medication	Dose	Directions	Quantity	Refills
<input type="checkbox"/> Eplusa®	400 mg/100 mg	Take 1 tablet by mouth once daily with or without food	28	
<input type="checkbox"/> Zepatier™	50 mg/100 mg	Take 1 tablet by mouth once daily with or without food	28	
<input type="checkbox"/> Harvoni®	90 mg/400 mg	Take 1 tablet by mouth once daily with or without food	28	
<input type="checkbox"/> Vosevi™	400/100/100mg	Take 1 tablet by mouth once daily with food	28	
<input type="checkbox"/> Olysio®	150 mg	Take 1 capsule by mouth once daily	28	
<input type="checkbox"/> Daklinza®	<input type="checkbox"/> 60 mg <input type="checkbox"/> 30 mg*	Take 1 tablet by mouth once daily with or without food *30 mg dose is utilized when given in combination with strong CYP3A inhibitors. 90 mg dose is to be administered when given in combination with moderate inducers of CYP3A.	28	
<input type="checkbox"/> Sovaldi®	400 mg	Take 1 tablet by mouth once daily	28	
<input type="checkbox"/> Technivie™ (ombitasvir, paritaprevir, ritonavir)	12.5/75/50 mg	Take 2 tablets by mouth once daily in the morning with a meal	56	
<input type="checkbox"/> Viekira™ Pak (ombitasvir, paritaprevir, ritonavir, dasaburvir)	12.5/75/50/250 mg	Take 2 ombitasvir/paritaprevir/ritonavir tablets once daily (in the morning) and 1 dasaburvir tablet twice daily (morning and evening) with a meal	112	
<input type="checkbox"/> Viekira™ XR (ombitasvir, paritaprevir, ritonavir, dasaburvir)	8.33/50/33.33/200 mg	Take 3 tablets by mouth once daily with food	84	
<input type="checkbox"/> RibaPak® Dose Pack <input type="checkbox"/> Moderiba™ Dose Pack <input type="checkbox"/> Moderiba™ Tabs <input type="checkbox"/> Ribavirin/Ribasphere® <input type="checkbox"/> Capsule <input type="checkbox"/> Tablet	<input type="checkbox"/> 600 mg/400 mg <input type="checkbox"/> 600 mg/600 mg 200 mg	<input type="checkbox"/> Take 600 mg by mouth in the morning and 400 mg by mouth in the evening <input type="checkbox"/> Take 600 mg by mouth in the morning and 600 mg by mouth in the evening <input type="checkbox"/> Other:	<input type="checkbox"/> 28 x 400 mg + 28 x 600 mg <input type="checkbox"/> 56 x 600 mg <input type="checkbox"/> 140 x 200 mg <input type="checkbox"/> 168 x 200 mg <input type="checkbox"/>	
Prescriber Signature and Date (Please sign and date below)				
Substitution Permissible		Date	Dispense as Written	Date
Check here to authorize the receiving pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process and receive forms on the prescriber's behalf. "I certify that the above therapy is medically necessary and the above information is accurate to the best of my knowledge"				

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