

## Patient Information – Please attach a copy of the patient’s insurance card

|   |  |                               |         |   |      |
|---|--|-------------------------------|---------|---|------|
| Patient Name:   |  | Date of Birth:                |         | <input type="checkbox"/> Male <input type="checkbox"/> Female |      |
| Address:  |  |                               | City:   | State:  | Zip: |
| Phone Number:   |  | Alternate Phone Number:       |         | Language:   |      |
| <b>Allergies (Required):</b>  |  | <input type="checkbox"/> NKDA | Height: | Weight:   | SSN: |
| <b>Product Shipping Options:</b> <input type="checkbox"/> Patient’s Home <input type="checkbox"/> Prescriber Office <input type="checkbox"/> Alternative Address: |  |                               |         |   |      |

## Prescriber Information

|                   |  |  |                 |        |      |
|-------------------|--|--|-----------------|--------|------|
| Practice Name:    |  |  | Office Contact: |        |      |
| Prescriber:       |  |  | NPI:            |        | DEA: |
| Practice Address: |  |  | City:           | State: | Zip: |
| Phone Number:     |  |  | Fax Number:     |        |      |

## Clinical Information – Please send all available chart notes including lab results

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| ICD-10/Diagnosis:  |  | 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<br>If yes, is it <input type="checkbox"/> compensated <input type="checkbox"/> decompensated  |  | Fibrosis stage: <input type="checkbox"/> F0 <input type="checkbox"/> F0-F1 <input type="checkbox"/> F1 <input type="checkbox"/> F1-F2<br><input type="checkbox"/> F2 <input type="checkbox"/> F2-F3 <input type="checkbox"/> F3 <input type="checkbox"/> F3-F4 <input type="checkbox"/> F4<br>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<br>eGFR: _____ mL/min/1.73m <sup>2</sup> |  |
| 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<br>For Olysio® order, is the Q80K polymorphism present? <input type="checkbox"/> Yes <input type="checkbox"/> No |  | Baseline viral load (IU/mL):<br>Baseline viral load (Log IU/mL):  |  | Is the patient interferon intolerant?<br><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                            |  |
| NS5A Test results: <input type="checkbox"/> resistant <input type="checkbox"/> non-resistant   |  | Y93H Mutation detected? <input type="checkbox"/> Yes <input type="checkbox"/> No  |  | Hep B panel: <input type="checkbox"/> HBsAg <input type="checkbox"/> HBCAb <input type="checkbox"/> HBsAb  |  |

## Prescription Information

| Medication   | Dose   | Directions   | Quantity   | Refills |
|--|--|--|--|---------|
| <input type="checkbox"/> Mavyret™  | 100 mg / 40 mg   | Take 3 tablets by mouth once daily with food   | 84   |         |
| <input type="checkbox"/> Zepatier™   | 50 mg/100 mg   | Take 1 tablet by mouth once daily with or without food   | 28   |         |
| <input type="checkbox"/> Eplclusa®   | 400 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"/> Sovaldi®  | 400 mg   | Take 1 tablet by mouth once daily with or without food   | 28   |         |
| <input type="checkbox"/> Daklinza®   | <input type="checkbox"/> 60 mg<br><input type="checkbox"/> 30 mg*          | Take 1 tablet by mouth once daily with or without food<br><small>*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.</small>                         | 28   |         |
| <input type="checkbox"/> Olysio®   | 150 mg   | Take 1 capsule by mouth once daily with or without food  | 28   |         |
| <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"/> Ribavirin   | 200 mg<br><input type="checkbox"/> Capsule <input type="checkbox"/> Tablet | <input type="checkbox"/> Take 600 mg by mouth in the morning and 400 mg by mouth in the evening with food - (for patients ≤ 165 lbs)<br><input type="checkbox"/> Take 600 mg by mouth in the morning and 600 mg by mouth in the evening with food - (for patients ≥ 165 lbs) | <input type="checkbox"/> 140<br><input type="checkbox"/> 168 |         |

## Prescriber Signature and Date (Please sign and date below)

|  |      |                          |      |
|--|------|--------------------------|------|
| Dispense as Written  | Date | Substitution Permissible | Date |
| <input type="checkbox"/> Check here to authorize Curexa® 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 |      |                          |      |

**Important Notice:** This form and its contents may contain private and confidential information that is intended for the individual or entity to which it is addressed. This transmission may contain information that is exempt from disclosure under laws including but not limited to the Health Insurance Portability and Accountability Act (HIPAA). Unless explicitly stated, you are strictly prohibited from disseminating, copying or distributing any material contained within. Violators will be prosecuted to the fullest extent of the law. If you received this communication in error, please notify us immediately and destroy this form and its contents.