

For assistance, contact your pharmacy representative: \_\_\_\_\_ Phone: \_\_\_\_\_ (For providers only)

**PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.**

**Note:** This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital (may not be faxed by patient).



## Hepatitis C Prescription/Pharmacy Intake Form

Pharmacy: \_\_\_\_\_  
Pharmacy Fax: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_  
Date Needed: \_\_\_\_\_ Ship To:  Prescriber's Office  Patient's Home  Other: \_\_\_\_\_

### PATIENT INFORMATION

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Phone # (Daytime): \_\_\_\_\_ Phone # (Evening): \_\_\_\_\_  
Insurance provider (Please include copy of front and back of card): \_\_\_\_\_  
ID #: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_  Patient is eligible for Medicare

### CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription

Patient is:  Naïve  Relapser  Null Responder  Partial Responder  Reinfection Anticipated Length of Treatment: \_\_\_\_\_  
ICD-10 code: \_\_\_\_\_ ICD-10 description: \_\_\_\_\_  
Weight: \_\_\_\_\_  lb  kg Date: \_\_\_\_\_ Height: \_\_\_\_\_  in  cm Date: \_\_\_\_\_  
Genotype:  1  1a  1b  2  3  4  5  6  
 Positive for Q80K Polymorphism NS5A Polymorphism:  Yes  No NS5A Polymorphism Type:  M28  Q30  L31  Y93  Other: \_\_\_\_\_  
Initial Viral Load: \_\_\_\_\_ Date: \_\_\_\_\_  
Prior Therapy: \_\_\_\_\_ End Date: \_\_\_\_\_ Weeks of Therapy: \_\_\_\_\_  Naïve  Partial Responder  Non Responder  Relapser  
Prior Therapy: \_\_\_\_\_ End Date: \_\_\_\_\_ Weeks of Therapy: \_\_\_\_\_  Naïve  Partial Responder  Non Responder  Relapser  
Fibrosis Score:  F<sub>0</sub>  F<sub>1</sub>  F<sub>2</sub>  F<sub>3</sub>  F<sub>4</sub> Cirrhosis:  None  Compensated  Decompensated Transplant Status:  N/A  Awaiting Transplant  Post Transplant  
Other Health Conditions, Allergies, Concomitant Medications: \_\_\_\_\_  
Please indicate what, if any, documents to assist with prior authorizations are attached: \_\_\_\_\_

Medication	Dose/Directions/Frequency	Qty	Refills
<input type="checkbox"/> Epclusa 400/100mg tablets			
<input type="checkbox"/> Harvoni 90/400mg tablets			
<input type="checkbox"/> Mavyret 100/40mg tablets			
<input type="checkbox"/> Sovaldi 400mg tablets			
<input type="checkbox"/> Vosevi 400/100/100mg tablets			
<input type="checkbox"/> Zepatier 50/100mg tablets			
<input type="checkbox"/> Moderiba 200mg tablets			
<input type="checkbox"/> Ribasphere 200mg tablets			
<input type="checkbox"/> Moderiba Dose Pack <input type="checkbox"/> Ribasphere Ribapak <input type="checkbox"/> 600mg/day = 200-400: 200mg AM/400mg PM <input type="checkbox"/> 800mg/day = 400-400: 400mg AM/400mg PM <input type="checkbox"/> 1,000mg/day = 600-400: 600mg AM/400mg PM <input type="checkbox"/> 1,200mg/day = 600-600: 600mg AM/600mg PM <input type="checkbox"/> Ribavirin <input type="checkbox"/> 200mg tablets <input type="checkbox"/> 200mg capsules			

### PRESCRIBER INFORMATION

Prescriber's name: \_\_\_\_\_ Practice/facility: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Office contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Email: \_\_\_\_\_ Best time to call: \_\_\_\_\_ Preferred method of contact:  Email  Phone  Fax  
State license #: \_\_\_\_\_ DEA #: \_\_\_\_\_ NPI #: \_\_\_\_\_ Medicaid UPIN #: \_\_\_\_\_

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

Dispense as written

Substitution permitted

Date

\*\*\* THIS FORM IS NOT VALID IN THE STATE OF ALABAMA \*\*\*

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. Drug names are the property of their respective owners.