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)**.

allianceRx Walgreens Pharmacy

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_0 ☐F_1 ☐F_2 ☐F_3 ☐F_4 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
☐Epclusa 400/100mg tablets			
☐Harvoni 90/400mg tablets			
☐Mavyret 100/40mg tablets			
☐Sovaldi 400mg tablets			
☐Vosevi 400/100/100mg tablets			
☐Zepatier 50/100mg tablets			
☐Moderiba 200mg tablets ☐Ribasphere 200mg tablets			
☐Moderiba Dose Pack ☐Ribasphere Ribapak ☐600mg/day = 200-400: 200mg AM/400mg PM ☐800mg/day = 400-400: 400mg AM/400mg PM ☐1,000mg/day = 600-400: 600mg AM/400mg PM ☐1,200mg/day = 600-600: 600mg AM/600mg PM ☐Ribavirin ☐200mg tablets ☐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.