

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"/> N5SA 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	

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 administer with sofosbuvir	_____ 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.)