Phone: 800-818-6486 ◆ Fax: 800-818-6490

Prescription & Enrollment Form – Hepatitis C

Patient Information

Demographics do not need to be completed if a demographic sheet is to follow

Patient:______________________________DOB:______________Last 4 digits of SSN:__________

Address:______________________City:______________________State:________Zip:__________

Cell #:______________Home #:______________Gender: ☐ M ☐ F ***Ship initial dose to:*** ☐ ***Patient*** ☐ ***Office***

Insurance Information

To expedite the benefits investigation, please attach:

☐ ***Enlarged copy - front & back of insurance card*** ☐ ***Chart notes*** ☐ ***Labs*** ☐ ***Supporting clinical documentation & med/allergy list***

Insurance:______________________***Pharmacy Help Desk Phone:***______________________

ID Number:______________________***Group Number:***______________________

Rx Group:______________***Rx BIN:***______________***Rx PCN:***______________

Patient Assessment

Dx: ☐ Hepatitis C (chronic) 070.54 ☐ Hepatitis B ICD-9:________ Weight:________Genotype **(check one)**: ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

Viral Load:______________Date of Viral Load:______________Length of Treatment:________weeks Awaiting liver transplant? ☐ Yes ☐ No

Previously Treated? ☐ Yes ☐ No ***If yes,*** products:______________________Dates Treated:______________

Check one: ☐ Relapsed ☐ Non-Compliance ☐ Non-Responder

☐ FibroScan® ☐ FibroSURE™ ☐ Liver Biopsy **Results:**______________________bc

Co-morbidities: ☐ Anemia ☐ Depression ☐ Diabetes ☐ Hypertension ☐ Organ Transplant ☐ HIV

☐ Seizure disorder ☐ Patient or partner pregnant ☐ Other ______________________

Has patient abstained from alcohol for past 6 months? ☐ Yes ☐ No ***If no***, is patient enrolled in treatment program? ☐ Yes ☐ No

Prescription Information

HARVONI® (ledipasvir 90 mg/sofosbuvir 400 mg)
Disp ______ ***month(s) supply*** ***Refills:***______
☐ Take orally once each day

OLYSIO® (simeprevir) **Q80K results:**__________
Disp ______ ***month(s) supply*** ***Refills:***______
☐ 150 mg orally once each day with food

SOVALDI® (sofosbuvir)
Disp ______ ***month(s) supply*** ***Refills:***______
☐ 400 mg orally once each day

VIEKIRA PAK™ (ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg, dasabuvir 250 mg)
Disp ______ ***month(s) supply*** ***Refills:***______
☐ Two tablets ombitasvir, paritaprevir, ritonavir 12.5/75/50 mg once daily (in the morning) and one dasabuvir 250 mg tablet twice daily (morning & evening) with a meal without regard to fat or calorie content

OTHER Drug:______________________
Sig:______________________
Qty:______________Refills:______________

☐ **RIBAPAK® *** **OR** ☐ **MODERIBA™ *** (check one)
Disp ______ ***month(s) supply*** ***Refills:***______
☐ 200 – 400 (600 mg/day)
☐ 400 – 400 (800 mg/day)
☐ 600 – 400 (1000 mg/day)
☐ 600 – 600 (1200 mg/day)

Co-pay assistance available with certain restrictions. Government programs are not included.

***To ensure brand name, please handwrite "Brand Medically Necessary" below.**
____

RIBAVIRIN 200 mg ☐ **CAPSULES** ☐ **TABLETS**
Disp ______ ***month(s) supply*** ***Refills:***______
Total Daily Dose Equals ________mg/day
Sig: Take ________ Caps/Tabs PO Qam and _______ Caps/Tabs PO Qpm

PEGINTRON® REDIPEN®
Disp ______ ***month(s) supply*** ***Refills:***______

Concentration	**Sig:**
☐ 120 mcg/0.5 mL	Inject 0.4 mL SQ weekly
☐ 120 mcg/0.5 mL	Inject 0.5 mL SQ weekly
☐ 150 mcg/0.5 mL	Inject 0.5 mL SQ weekly

PEGASYS®
Disp ______ ***month(s) supply*** ***Refills:***______
☐ 180 mcg SQ weekly #4
☐ 135 mcg SQ weekly #4
☐ 90 mcg SQ weekly #4
☐ ProClick™ or
☐ Prefilled syringe

Practice Name:______________________**Provider Name:**______________________

Provider Tax ID #:______________**License #:**______________**DEA #:**______________**NPI #:**______________

Address:______________________**City:**______________**State:**__________**Zip:**__________

Office Contact:______________________**Phone:**______________**Fax:**______________

❑ ***Physician's office to train*** ❑ ***Patient training to be coordinated by PSI*** ❑ ***Uninsured patient, needs assistance***

PRESCRIBER SIGNATURE:______________________________**DATE:**______________

PSI122014