Chronic Hepatitis C
Enrollment Form

Phone: 844-309-7172
Fax: 844-309-7173

1. PATIENT INFORMATION

Patient Name	☐ Male ☐ Female	Allergies	
Date of Birth	SSN#	Patient Weight lb/kg Height In/cm	
Address	City	State	Zip
Phone # (Home)	(Work)	Email address	

2. INSURANCE INFORMATION

Primary Insurance	Pharmacy Ins: BIN_____ PCN_____	Policyholder
Group #	Policy #	Phone #
Secondary Insurance	Policy#	Phone #

3. DIAGNOSIS/MEDICAL INFORMATION (PLEASE ANSWER ALL QUESTIONS TO PREVENT A DELAY IN PATIENT'S THERAPY.)

☐ K73 Hepatitis C (Chronic)	☐ Other ICD 10 _____	Genotype: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other	☐ Initial HCV Therapy- therapy naive ☐ Non-responder/partial responder/relapser	Pre-Treatment HCV RNA level _____IU/mL Date_____

Criteria:

1) Hepatitis B negative? ☐ yes ☐ no Date tested? _____
2) HIV tested? ☐ yes ☐ no Date tested? _____ Co infection? ☐ yes ☐ no ☐ NA
3) Female Patient of Child Bearing Potential: Has the patient had a negative pregnancy test? ☐ yes ☐ no ☐ NA
4) Female/Male Patient of Child Bearing Potential: Has patient been counseled on teratogenic effects of ribavirin & willing to practice contraception during & for 6 months after completion of therapy? ☐ yes ☐ no ☐ NA
5) Has the patient/caregiver been educated on the importance of medication adherence and is willing to adhere for the full course of therapy? ☐ yes ☐ no

4. PRESCRIPTION INFORMATION

Medication	Dose	Frequency	Quantity#	Genotype	Refills
☐ Epclusa® (sofosbuvir-velpatasvir)	1 tab	once daily	12 wks min	all six	
☐ Mavyret (glecaprevir-pibrentasvir)	3 tabs	once daily	8 wks min	all six	
☐ Harvoni® (ledipasvir-sofosbuvir)	1 tab	once daily	8-12 wks min	1,4,5,6	
☐ Zepatier® (elbasvir-grazoprevir)	1 tab	once daily	12 wks min	1 and 4	
☐ Vosevi®* (sofosbuvir-velpatasvir-voxilaprevir)	1 tab	once daily	various	All six	
☐ Other					
☐ Other					

*Indicated for **retreatment** of all genotypes that failed to respond on previous medications with sofosbuvir
#RECHECK HCV RNA levels after minimum 8 to 12 weeks of drug therapy

5. DELIVERY INSTRUCTIONS

☐ Physicians Office	☐ Other	Date Medication Needed
☐ Patient's Home	Address	
	City/State/Zip	

6. PHYSICIAN CONTACT INFORMATION & AUTHORIZATION

Physician Name	Office Contact	Institution
Phone	Fax	Specialty
Address		City/State/Zip
NPI #		DEA #

Physician's Signature _____ **Date** _____
(required to process prescription – stamped signatures are not permissible)

Please fax to AllyScripts Specialty Pharmacy at 844-309-7173.
Faxed prescription forms will only be accepted from prescribing practitioners.