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HEPATITIS C ENROLLMENT FORM

Prescribing Practitioner:	NPI:
Supervising Physician:	NPI:
Address:	Tax ID:
Office:	Fax:
Contact:	

PATIENT INFORMATION

Name:	☐ M ☐ F	**DOB:** ____/____/____	**SS#:** ____-____-____
Street:	**City:**	**Style:**	**Zip:**
Tel:	**Alt. Tel:**	☐ English ☐ Spanish ☐ Other:_____	**Wt.:** _____ **Ht.:** _____

PRESCRIPTION

☐ New ☐ Refill **Ship by:** ____/____/____ **SHIP TO:** ☐ Patient's Home ☐ Doctor's Office ☐ Other: _____

DRUG	STRENGTH	DIRECTIONS & QUANTITY	REFILLS
EPCLUSA	☐ 400/100 MG TABLET (SOFOSBUVIR/VELPATASVIR)	TAKE 1 TABLET PO QD WITH OR WITHOUT FOOD (QUNATITY:28)	
HARVONI	☐ 400/90 MG TABLET (SOFOSBUVIR/LEDIPASVIR)	TAKE 1 TABLET PO QD WITH OR WITHOUT FOOD (QUNATITY:28)	
MAVYRET	☐ 100/40 TABLET (GLECAPREVIR/PIBRENTASVIR)	TAKE 3 TABLET PO QD WITH FOOD (QUANTITY: 84)	
SOVALDI	☐ 400 MG TABLET (SOFOSBUVIR)	TAKE 1 TABLET PO QD WITH OR WITHOUT FOOD (QUANTITY: 28)	
VIEKIRA PAK	☐ 12.5/75/50 MG TABLET (OMBITASVIR/PARITAPREVIR/RITONAVIR/DASABUVIR)	TAKE 2 PINK TABLETS PO QD (MORNING) AND 1 BEIGE TABLET PO BID (MORNING & EVENING) WITH A MEAL (QUANTITY : 56/56)	
VOSEVI	☐ 400/100/100 MG TABLET (SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR)	TAKE 1 TABLE PO QD WITH FOOD (QUANTITY: 28)	
ZEPATIER	☐ 50/100 MG TABLET (ELBASVIR/GRAZOPREVIR)	TAKE 1 TABLE PO QD WITH OR WITHOUT FOOD (QUANTITY: 28)	

RIBAVIRIN PRODUCTS / DIRECTIONS & QUANTITY

☐ TAKE 100 MG QAM, 600 MG QPM (QUANTITY: 140)
☐ TAKE 600MG QAM, 600 MG QPM (QUANTITY: 168)
☐ TAKE ___MG QAM, ___ MG QPM (QUANTITY: ___)

☐ COPEGUS TABLET ☐ RIBASPHERE ☐ RIBASPHERE RIBAPAK
☐ RIBAVRIN TABLET ☐ RIBAVRIN CAPSULE

MEDICAL INFORMATION

*** PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY***

DIAGNOSIS: ☐ B18.2 CHRONIC HEPATITIS C VIRUS (HCV) DATE OF DIAGNOSIS: ____/____/_____ TREATMENT NAIVE? ☐ YES ☐ NO

GENOTYPE: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 SUBTYPE: ☐ A ☐ B ☐ A/B ☐ N/A BASELINE VIRAL LOAD: _____ IU/ML DATE: ____/____/_____

CIRRHOSIS: ☐ YES ☐ NO (IF YES, IS IT: ☐ COMPENSATED ☐ DECOMPENSATED) CO-INFECTION STATUS: ☐ HIV ☐ HBV ☐ N/A

DEGREE OF LIVER FIBROSIS: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4 POLYMORPHISM(S): ☐ NS5A ☐ IL28B ☐ Q80K ☐ N/A

PRIOR HCV TREATMENT:	DATE(S) OF TREATMENT:	TREATMENT WEEKS:	TREATMENT RESPONSE:
			☐ INCOMPLETE ☐ NULL ☐ PARTIAL ☐ RELAPSED
			☐ INCOMPLETE ☐ NULL ☐ PARTIAL ☐ RELAPSED

ALLERGIES: _____ EXPECTED DURATION OF THERAPY ☐ 8 WEEKS ☐ 12 WEEKS ☐ 16 WEEKS ☐ 24 WEEKS

ADDITIONAL CLINICAL INFORMATION:

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing TODT Hill Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations

Prescribing Practitioner: **Date:** _____/_____/_____

CONFIDENTIALITY NOTICE