

Medwin's Pharmacy

Phone: (989) 755-7998

Fax Referral to: (989) 755-7993

Hepatitis C Enrollment Form

PATIENT INFORMATION

Please fax copy of patient's insurance card including both sides

Patient Name _____
 DOB _____ Last Four of SS# _____ Gender _____
 Weight _____ Height _____ Phone _____
 Address _____
 City, State, ZIP _____
 Language Preference: English Spanish Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____
 DEA _____ NPI _____
 Group/Hospital _____
 Address _____
 City, State, ZIP _____
 Phone _____ Fax _____
 Contact Person _____ Phone _____

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number _____

MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

B18.2 Chronic Hepatitis C K72.90 Hepatic failure, unspecified without coma C22.0 Liver Cell Carcinoma
 Other Diagnosis: ICD-10 Code _____ Description _____
 Genotype _____ Viral Load _____ IU/ml Viral Load Date _____ HIV Coinfected: Yes No HBV Coinfected: Yes No
 Previous therapy history: Naïve _____ Relapsed _____ Partial Responder _____ Null _____
 Date(s) of previous therapy and meds _____
 Cirrhosis: Yes No Compensated OR Decompensated Fibrosis Score _____
 Liver Transplant: Yes No Waiting for Liver Transplant: Yes No

Please include hard copies of: genotype, viral load, liver biopsy scans, CBC, CMP, HIV, PT/INR, H&P, NS5A resistance testing and pertinent office visit notes.

PRESCRIPTION INFORMATION

DAKLINZA® (daclatasvir) 30mg 60mg Disp. 28 Sig: One tablet daily with or without food. Refill: x _____ Total duration of therapy _____ Weeks

TECHNIVIE™ Disp. 28 day supply Sig: Take 2 tablets once daily (in am) with food. Refill: x _____ Total duration of therapy _____ Weeks

VOSEVI Disp. 28 day supply Sig: Take once daily with food Refill: x _____ Total duration of therapy _____ Weeks

ZEPATIER (elbasvir 50mg/grazoprevir 100mg) disp. 28 Refill: x _____ duration of therapy _____ Weeks
 Sig: Take 1 tablet daily with or without food. NS5A resistance testing included

RIBAVIRIN 200mg:

Directions _____
 Quantity _____
 Refill: x _____ Total duration of therapy _____ Weeks
 < 75kg = 1000mg/day
 ≥ 75kg = 1200mg/day

RIBAPAK (28 day supply):

1200mg daily/600mg QAM—600mg QPM
 1000mg daily/600mg QAM—400mg QPM
 800mg daily/400mg QAM—400mg QPM
 600mg daily/200mg QAM—400mg QPM
 Refill: x _____ Total duration of therapy _____ Weeks

MODERIBA (28 day supply):

1200mg daily/600mg QAM—600mg QPM
 1000mg daily/600mg QAM—400mg QPM
 800mg daily/400mg QAM—400mg QPM
 600mg daily/200mg QAM—400mg QPM
 Refill: x _____ Total duration of therapy _____ Weeks

SOVALDI™ (sofosbuvir) 400mg disp. 28 Sig: 400mg daily Refill: x _____ Total duration of therapy _____ Weeks

EPLCUSA (sofosbuvir 400mg/velpatasvir 100mg) disp. 28 Sig: 1 tablet daily Refill: x _____ Total duration of therapy _____ Weeks

VIEKIRA XR disp. 84 tabs (28 day supply) Sig: Take 3 tablets by mouth once daily. Refill: x _____ duration of therapy _____ Weeks

VIEKIRA PAK disp. 28 day supply. Refill: x _____ duration of therapy _____ Weeks

Sig: Take 2 ombitasvir, paritaprevir, ritonavir 12.5mg/75mg/50mg tablets once daily (in am) and 1 dasabuvir 250mg tablet twice daily (am & pm) with a meal.

HARVONI® (ledipasvir 90mg/sofosbuvir 400mg) disp. 28 Sig: 1 tablet daily Refill: x _____ Total duration of therapy _____ Weeks

MAVYRET™ (glecaprevir 100mg/pibrentasvir 40mg) disp 84 Refill: x _____ Total duration of therapy _____ Weeks
 Sig: Take 3 tablets (contents of one daily dose card) by mouth once daily with food.

Supportive Therapy: **PROMACTA® PO QD** 12.5mg tablets 25mg tablets 50mg tablets 75mg tablets 100mg tablets
 Quantity _____ Refill: x _____ Total duration of therapy _____ Weeks ***Titrate based on platelet count not to exceed 100mg PO QD**

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to: Patient Office First Fill Office ALL fills Other _____ Date _____ Needs by Date _____
 (future fills to Patient)

Product Substitution permitted Dispense as Written

Prescriber's Signature _____ Date _____ Supervising physician _____ Date _____

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.