HEPATITIS C ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 **FAX:** 800-530-8589 **WEB:** www.HealthDyneSpecialty.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

PATIENT INFORMATION

Patient: _____ Caregiver: _____

DOB: _____ ☐ Male ☐ Female Weight: _____ ☐ kgs or ☐ lbs (check one) Height: _____ ☐ in or ☐ cm (check one) Recorded Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Best Phone #:_____ ☐ Cell Alternate Phone #:_____ ☐ Cell Email:_____

Allergies: _____ Latex Allergy: ☐ Yes ☐ No

ICD-10 Code for requested therapy: _____ ICD-10 Code(s) for other medical conditions: _____

MEDICAL ASSESSMENT

PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION

Diagnosis Date: _____

Genotype: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 Subtype: ☐ A ☐ B ☐ A/B ☐ N/A

Baseline viral load: _____ Date: _____

Degree of fibrosis: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4 ☐ _____

Cirrhosis: ☐ None ☐ Compensated ☐ Decompensated (CTP: ☐ B ☐ C)

☐ Treatment naïve ☐ Treatment experienced

☐ Prior treatment (list): _____

_____

_____

_____

_____

☐ Failed therapy (list): _____

_____

_____

_____

Transplant status: ☐ N/A ☐ Pre-transplant ☐ Post-transplant

sCr: _____ GFR: _____ Date: _____

CKD stage: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ N/A Dialysis: ☐ Yes ☐ No

IL28B polymorphism: ☐ CC ☐ CT ☐ TT

Q80K polymorphism: ☐ Yes ☐ No

NS5A polymorphism: ☐ Yes ☐ No

NS5A polymorphism type: ☐ M28 ☐ Q30 ☐ L31 ☐ Y93 ☐ _____

PLEASE PROVIDE ALL CLINICAL INFORMATION INCLUDING LAB RESULTS ON ALL FORMS

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Epclusa® (sofosbuvir/velpatasvir)	☐ 400 mg sofosbuvir/100 mg velpalasvir per tablet	Take one tablet once daily with or without food.	28 day supply	Total Therapy: ☐ 12 weeks
Harvoni® (ledipasvir/sofosbuvir)	☐ 90 mg ledipasvir/400 mg sofosbuvir per tablet ☐ 45/200 (only for brand name)	Take orally once daily with or without food. Do not take within 4 hours of antacids.	28 day supply	Total Therapy: ☐ 8 weeks ☐ 12 weeks ☐ 24 weeks
Lepidasvir/Sofosbuvir (generic for Harvoni)	90/400	Take orally once daily with or without food. Do not take within 4 hours of antacids.	28 day supply	Total Therapy: ☐ 8 weeks ☐ 12 weeks ☐ 24 weeks
Mavyret (Glecaprevir/Pibrentasvir)	100/40	3 tablets one time daily with food	28 day supply	Total Therapy: ☐ 8 weeks ☐ 12 weeks
Ribavirin (Ribasphere®)	☐ 200 mg tablets ☐ 200mg capsules ☐ 200 mg tablets ☐ 400 mg tablets ☐ 600 mg tablets	Take _____ tabs/caps orally q am and _____ tabs/caps q pm for a total of _____ mg daily	28 day supply	
Ribasphere® RibaPak®	☐ 600/600 mg ☐ 600/400 mg ☐ 400/400 mg ☐ 200/400 mg	Take _____ mg orally q am and _____ q pm for a total of _____ mg daily	28 day supply	
Sofosbuvir/Velpatasvir (generic for Epclusa)	400/100	1 tablet daily with or without food.	28 day supply	Total Therapy: ☐ 12 weeks
Sovaldi® (sofosbuvir)	400 mg tablets	Take one 400 mg tablet orally once a day with or without food	28 day supply	
Viekira Pak™ (Dasabuvir Oral tablet/Ombitasvir/ Paritaprevir/Ritonavir)	250mg Dasabuvir/ 12.5mg Ombitasvir/ 75mg Paritaprevir/50mg Ritonavir	Take 2 pink tablets (ombitasvir, paritaprevir, ritonavir) once daily (morning) and 1 beige tablet (dasbuvir) twice daily (morning and evening) with meals.	28 day supply	Total Therapy: ☐ 12 weeks ☐ 24 weeks

(Continued on page 2)

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Patient: _____ DOB: _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Vosevi (Sofosbuvir/Velpatasvir/ Voxilaprevir)	400/100/100	1 tablet daily with food. Do not take within 4 hours of antacids containing AL or Mag.	28 day supply	Total Therapy: ☐ 12 weeks
Zepatier™ (elbasvir/grazoprevir)	☐ 50 mg elbasvir/100 mg grazoprevir per tablet	Take one tablet daily with or without food	28 day supply	Total Therapy: ☐ 12 weeks ☐ 16 weeks
Other				

PRESCRIBER INFORMATION

INJECTION TRAINING: **OFFICE TO COORDINATE** **HEALTHDYNE SPECIALTY TO COORDINATE**

Anticipated Start Date: _____ Prescriber Specialty: _____

Ship to: ☐ Patient ☐ Physician ☐ Clinic ☐ Other: _____

Fax #: _____ Contact Name: _____

Office Address: _____ City: _____ State: _____ Zip: _____

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☐ I understand that HealthDyne Specialty may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.

Prescriber's Name: _____ Prescriber's Signature: _____ Date: _____

☐ Use substitution ☐ Dispense as written

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