

Date Required: _____ Ship To: Home Office Other: _____

PATIENT INFORMATION

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Cell Phone: _____
 Alternate Phone: _____
 Date of Birth: _____ Gender: Male Female

PRESCRIBER INFORMATION

Prescriber Name: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____
 Fax: _____
 DEA #: _____ NPI #: _____
 Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
 Secondary Insurance: _____ ID: _____ Group: _____
 Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

DIAGNOSIS & LAB WORK (Please attach clinical notes for prior authorization process)

Primary Diagnosis: 070.54 Hepatitis C Chronic Genotype: 1a 1b 2 3 4 HIV Co-Infected: Yes No
Compensated Cirrhosis? Yes No Weight: _____ Patient Allergies: NDKA Yes _____
Previously Treated with Interferon? No, patient is Naïve Yes **If yes, patient is a:** Partial Responder Relapser Null Response
Labwork: Baseline HCV-RNA: _____ Date: _____ Result: _____ IU/ml
 CBC Hepatic Function Panel or CMP HCV RNA QN Q80K Liver Biopsy and / or Fibrosure / Fibrosan
 Liver Transplant: Yes No Waiting for a Liver Transplant: Yes No Hepatocellular Carcinoma: Yes No

PRESCRIPTION INFORMATION

Patient to be trained for medication administration in physician clinic.

Procrit 2,000 3,000 4,000 10,000
 Epogen Dose: _____ SIG: _____ QTY: _____ Refill: _____

Neupogen 300mcg 480mcg
 Dose: _____ SIG: _____ QTY: _____ Refill: _____

<input type="checkbox"/> Ribavirin 200mg Directions: _____ Quantity: _____ Refill: x _____ Total duration of therapy: _____ Weeks	RibaPak (28 day supply): <input type="checkbox"/> 1200mg daily / 600mg QAM— 600mg QPM <input type="checkbox"/> 1000mg daily / 600mg QAM— 400mg QPM <input type="checkbox"/> 800mg daily / 400mg QAM— 400mg QPM <input type="checkbox"/> 600mg daily / 200mg QAM— 400mg QPM Total duration of therapy: _____ Weeks	Moderiba (28 day supply): <input type="checkbox"/> 1200mg daily / 600mg QAM— 600mg QPM <input type="checkbox"/> 1000mg daily / 600mg QAM— 400mg QPM <input type="checkbox"/> 800mg daily / 400mg QAM— 400mg QPM <input type="checkbox"/> 600mg daily / 200mg QAM— 400mg QPM Total duration of therapy: _____ Weeks
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< 75kg = 1000mg/day
 ≥ 75kg = 1000mg/day

Inhibitor of HCV NS5A / Nucleotide Analog Inhibitor:
 HARVONI® (ledipasvir 90mg / sofosbuvir 400mg) disp. 28 Sig: 1 tablet daily Refill: x _____ Total duration of therapy: _____ Weeks

Protease Inhibitor:
 OLYSIO™ (simeprevir) 150mg caps disp. 28 Sig: 150mg daily with food Refill: x _____ Total duration of therapy: _____ Weeks

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

NS5A Inhibitor / NS3 / 4A Protease Inhibitor / Non-Nucleoside NS5B Palm Polymerase Inhibitor:
 VIEKIRA PAK disp. 28 day supply. Refill: x _____ Total duration of therapy: _____ Weeks
 Sig: Take two ombitasvir, paritaprevir, ritonavir 12.5mg / 75mg / 50mg tablets once daily (in am) and 1 dasabuvir 250mg tablet twice daily (am & pm) with a meal.

Pegasys: 180mcg Proclick Autoinjector 135mcg Proclick Autoinjector 180mcg / 0.5ml prefilled syringe
 Dose: _____ SC once weekly as directed _____ 1-month supply _____ Refill: x _____ Total duration of therapy: _____ Weeks

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 Signature: _____ **Date:** _____