HEPATITIS C VIRUS SPECIALTY CARE PROGRAM

❶ PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: ❍ M ❍ F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

❷ PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

❸ STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Diagnostic Information

Date of Diagnosis: _____ ICD-10: _____ Race: _____
Genotype: _____ Subtype: _____ Q80K: ❑ Positive ❑ Negative (For Genotype 1a)
Indicate Patient Status: ❑ Naïve ❑ Partial Responder ❑ Non-responder ❑ Null-responder ❑ Relapser
Duration of Previous Therapy: _____ Weeks From: _____ To: _____
Cirrhosis: ❑ No ❑ Yes If Yes: ❑ Compensated ❑ Decompensated
History of Liver Biopsy? ❑ No ❑ Yes If Yes, Please Attach Results
❑ Fibrosure or ❑ Fibroscan: Results: _____
Extra-Hepatic Manifestations: ❑ Ascites ❑ Hepatic Encephalopathy ❑ Thrombocytopenia
❑ Other: _____ Does the patient need liver transplantation? ❑ Yes ❑ No
History of prior liver decompensation? ❑ Yes ❑ No
HBsAg and anti-HBc Test: ❑ Positive ❑ Negative Date: _____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

Labs

ALT: _____ HGB: _____
AST: _____ HCV RNA: _____
PLT: _____ SrCr: _____
NS5A Resistance Assay: _____ Date: _____

Medication List and Contraindications

❑ Attach Medication List
Is the patient interferon ineligible? ❑ No ❑ Yes
❑ Anxiety ❑ Depression ❑ Pulmonary Abnormalities
❑ Renal Insufficiency ❑ Other: _____

❹ INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

❺ PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

❻ INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION: Duration of Therapy: ❑ 8 Weeks ❑ 12 Weeks ❑ 24 Weeks ❑ Other _____

Patient Name: _____ Patient's Date of Birth: _____

Medication (*Generic Available)	Dosage & Strength	Direction	QTY	Refills
❑ EPCLUSA® (SOFOSBUVIR/VELPATASVIR)	❑ 400 mg/100 mg Tablets ❑ 200 mg/50 mg Tablets ❑ 200 mg/50 mg Oral Pellets ❑ 150 mg/37.5 mg Oral Pellets	**Adult:** ❑ Take 400 mg/100 mg tablet(s) by mouth daily with or without food **Pediatric Patient 3 Years and Older:** ❑ <17 kg: Take one 150 mg/37.5 mg packet of pellets by mouth once daily ❑ 17 - 29 kg: Take one 200 mg/50 mg packet of pellets by mouth once daily OR Take one 200 mg/50 mg tablet by mouth once daily ❑ ≥30 kg: Take two 200 mg/50 mg packets of pellets by mouth once daily OR Take one 400 mg/50 mg tablet by mouth once daily		
❑ HARVONI® (LEDIPASVIR/SOFOSBUVIR)*	❑ 45/200mg Tablets ❑ 45/200mg Oral Pellets ❑ 33.75/150mg Oral Pellets ❑ 90/400mg Tablets	**Adult**: ❑ Take one 90/400mg tablet by mouth daily with or without food **Pediatric Patient 3 Years and Older:** ❑ ≥35kg: Take one 90/400mg tablet by mouth daily with or without food *OR* Take two 45/200mg tablets/packets of pellets by mouth daily with or without food ❑ 17-34kg: Take one 45/200mg tablet/packet of pellets by mouth daily with or without food ❑ <17kg: Take one 33.75mg/150mg packet of pellets by mouth daily with or without food	28 56 28 28	
❑ MAVYRET®(GLECAPREVIR/PIBRENTASVIR)	❑ 100/40mg Tablet ❑ 50 mg/20 mg Oral Pellets	**Adult:** ❑ Take three 100mg/40mg tablets by mouth at the same time once daily with food **Pediatric Patients 3 Years to Less than 12 Years Old:** ❑ <20kg: Take three 50mg/20mg packets of oral pellets once daily ❑ 20 - 29kg: Take four 50mg/20mg packets of oral pellets once daily ❑ 30 - 44kg: Take five 50mg/20mg packets of oral pellets once daily ❑ >45kg and >12 years and older: Take three 100mg/40mg tablets once daily		
❑ SOVALDI®	❑ 200mg Tablets ❑ 400mg Tablets ❑ 150mg Oral Pellets ❑ 200mg Oral Pellets	**Adult:** ❑ Take one 400mg tablet by mouth daily with or without food **Pediatric Patient 3 Years and Older:** ❑ ≥35kg: Take one 400mg tablet by mouth daily with or without food *OR* Take two 200mg tablets/packets of pellets by mouth daily with or without food ❑ 17-34kg: Take one 200mg tablet/packet of pellets by mouth daily with or without food ❑ <17kg: Take one 150mg packet of pellets by mouth daily with or without food	28 56 28 28	
❑ VOSEVI®	❑ 400/100/100mg Tablets	❑ Take one tablet by mouth once daily with food	28	
❑ RIBAVIRIN	❑ 200mg Tablets ❑ 200mg Capsules	❑ Take _____ tablets/capsules by mouth every morning and, ❑ Take _____ tablets/capsules by mouth every evening		
❑ ZEPATIER®	❑ 50/100mg Tablets	❑ Take one tablet by mouth daily with or without food	28	
❑ _____	_____	_____		

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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