HEPATOLOGY ENROLLMENT FORM

PATIENT INFORMATION

Last Name ______________________ First Name ______________________

Social Security No ______________________ Date of Birth ______________________

Sex □ M □ F Weight_____ Height_____ Allergies_________

Home Phone ______________________ Work/Mobile ______________________

Home Address ______________________

City ______________ State ______________ Zip ______________

PATIENT INSURANCE INFORMATION

Primary Medical Insurance ______________________ Medical Insurance Phone ______________________

Subscriber Name ______________________

Rx Card (PBM) ______________________ Group No ______________________

Prescription Card Bin # ______________________ PCN # ______________________

TREATMENT ARRANGEMENTS

•Start Date:______________ Ship Meds □ Home □ Doctor's Office

Teaching by: □ Home Health □ Doctor's Office □ Other:_____________

PRESCRIPTION INFORMATION

STATEMENT OF MEDICAL NECESSITY

Diagnosis:

□ B18.2 Hepatitis C □ Other ICD 10 ____ □ Initial Therapy □ Previous Therapy **Genotype**: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 Other Subtype: □ a □ b

□ HCV RNA Level ______________ □ Treatment Naïve □ Previous treatment __________________ Date __________

Prior treatment (Duration): From _________ To __________ Total of _________ Weeks □ Co-infection ◯ HIV ◯ HBV

Cirrhosis: □ Compensated □ De-compensated □ Hepatocellular Carcinoma □ HIV Status □ Post-Liver Transplant

Fibroscan: □ Yes □ No Score:_______ **History of Liver biopsy?**: □ Yes □ No □ N/A **Fibrosis**: □ Yes □ No □ F1 □ F2 □ F3 □ F4

DRUG	DIRECTION	QUANTITY	REFILLS
□ **HARVONI®** (ledipasvir/sofosbuvir) 90/400mg	Take 1 TABLET by mouth ONCE a day with or without meals	28 Tablets	___________
□ **ZEPATIER®** (elbasvir/grazoprevir) 50/100 mg	Take 1 TABLET by mouth ONCE a day with or without meals	28 Tablets	___________
□ **DAKLINZA® 30 mg** □ **DAKLINZA® 60 mg** (daclatasvir)	Take 1 TABLET by mouth ONCE a day with or without meals	28 Tablets	___________
□ **VIEKIRA PAK®** (ombitasvir/paritaprevir/ritonavir & dasabuvir)	Take TWO TABLETS of ombitasvir/paritaprevir/ritonavir and ONE TABLET of dasabuvir in the morning. Take ONE TABLET of dasabuvir in the evening	4 Packs (28 days supply)	___________
□ **SOVALDI®** (sofosbuvir) 400 mg	Take 1 TABLET by mouth ONCE a day with or without meals	28 Tablets	___________
□ **OLYSIO®** (simeprevir) 150 mg	Take 1 CAPSULE by mouth ONCE a daily	28 Capsules	___________
□ **TECHNIVIE®** (ombitasvir/paritaprevir/ritonavir)	Take TWO tablets (One Pack) by mouth ONCE a day	4 Packs (28 days supply)	___________
□ **RIBAPAK®** □ **MODERIBA®** (ribavirin)	□ 600mg □ 800 mg □ 1000 mg □ 1200 mg	28 days supply	___________

HEPATITIS B TREATMENT

□ **BARACLUDE** □ 0.5 mg Tablet □ 1 mg Tablet □ 0.05mg/mL Solution
Directions:________________________ Qty:________ Refill________

□ **VIREAD** □ 150 mg □ 200 mg □ 300 mg
Directions:________________________ Qty:________ Refill________

Physician Signature: X____________________________________ □ **DAW (Dispense as Written) Date:** ______________________

Physician Name: ______________________ **Phone:** ______________________ **Fax:** ______________________ **Office Contact:** ______________________

Physician Address: ______________________ **NPI:** ______________________ **DEA:** ______________________

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