

# 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
<input type="checkbox"/> <b>MAVYRET®</b> (Glecaprevir/Pibretasvir) 100/40mg	Take 3 tablets by mouth ONCE daily with meals.	28 Packs (84 Tablets)	
<input type="checkbox"/> <b>VOSEVI®</b> (Sofosbuvir/Velpatasvir & Voxilaprevir)	Take 1 TABLET by mouth ONCE a day with meals.	28 Tablets	
<input type="checkbox"/> <b>EPCLUSA®</b> (Sofosbuvir/Velpatasvir) 400/100mg	Take 1 TABLET by mouth ONCE a day with or without meals.	28 Tablets	
<input type="checkbox"/> <b>HARVONI®</b> (Ledipasvir/Sofosbuvir) 90/400mg	Take 1 TABLET by mouth ONCE a day with or without meals.	28 Tablets	
<input type="checkbox"/> <b>ZEPATIER®</b> (Elbasvir/Grazoprevir) 50/100mg	Take 1 TABLET by mouth ONCE a day with or without meals.	28 Tablets	
<input type="checkbox"/> <b>DAKLINZA® 30mg</b> <input type="checkbox"/> <b>DAKLINZA® 60mg</b> (Daclatasvir)	Take 1 TABLET by mouth ONCE a day with or without meals.	28 Tablets	
<input type="checkbox"/> <b>VIEKIRA XR®</b> (Paritaprevir/Ombitasvir/Ritonavir & Dasabuvir)	Take 3 TABLETS by mouth once daily.	28 Packs (84 Tablets)	
<input type="checkbox"/> <b>VIEKIRA PAK®</b> (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 (112 Tablets)	
<input type="checkbox"/> <b>SOVALDI®</b> (Sofosbuvir) 400mg	Take 1 TABLET by mouth ONCE a day with or without meals.	28 Tablets	
<input type="checkbox"/> <b>TECHNIVIE®</b> (Ombitasvir/Paritaprevir/Ritonavir)	Take 2 tablets (One Pack) by mouth ONCE a day.	28 Packs (84 Tablets)	
<input type="checkbox"/> <b>RIBAPAK®</b> <input type="checkbox"/> <b>MODERIBA®</b> (Ribavirin)	<input type="checkbox"/> 600mg <input type="checkbox"/> 800mg <input type="checkbox"/> 1000mg <input type="checkbox"/> 1200mg <input type="checkbox"/> Take _____ mg in the morning _____ mg in the evening	28 days supply	

### HEPATITIS B TREATMENT

**BARACLUDE**  0.5mg Tablet  1mg Tablet  0.05mg/mL Solution  **VIREAD**  150mg  200mg  300mg  **VEMLIDY**  25mg  
 Directions: \_\_\_\_\_ Qty: \_\_\_\_\_ Refill \_\_\_\_\_ 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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