Fax Referral To:
(814) 283-2211
Phone (855) 265-8008

HEPATITIS C
Enrollment Form

VALUE SPECIALTY PHARMACY

Order Status:		Desired Therapy Start Date		Delivery Site	
New		Date		Patient's Home	
Reauthorization		OR		Office/Clinic	
Restart		ASAP		Other (specify)	

Documents necessary for facilitation of referral:

1. Enrollment form
2. Front/Back copies of all insurance/prescription cards
3. Labwork/medication profile
4. Prescription

PATIENT INFORMATION				PRESCRIBER INFORMATION			
(Complete the following or send patient demographic sheet)				Prescriber's Name:			
Patient Name:				State License #:		UPIN:	
Address:				DEA #:		NPI #:	
City, State, Zip:				Group or Hospital:			
Home Phone:				Address:			
Alternate Phone:				City, State, Zip:			
SS #:				Phone:		Fax:	
Date of Birth:		Gender:	M F	Contact Person:		Phone:	

PRIOR AUTHORIZATION CRITERIA *(please circle where appropriate)*

Primary Diagnosis:		Additional Dx Codes:		Baseline Viral Load:	IU/mL
Weight lbs/kg:		Height in/cm:		Interferon Intolerant:	NO YES
Allergies:				Q80K Polymorphism:	NO YES
Genotype:	1a 1b 1 2 3 4 5 6			Cirrhosis:	NO YES if yes; COMP DECOMP
Child Pugh Score:	A B C			On PPI Therapy:	NO YES
Fibrosis Score:	F0 F1 F2 F3 F4			GFR:	mL/min
Activity Score:	A0 A1 A2 A3			Treatment Status:	Treatment Naïve Null Responder Partial Responder Relapser
Previously Tried or Failed Therapies:				Transplant Status:	N/A Awaiting Status-Post

PRESCRIPTION INFORMATION

THERAPY	✓	DIRECTIONS FOR USE	QUANTITY	REFILL/DURATION
Harvoni 90/400mg		Take one tablet each day	#28	
Olysio 150mg		Take one capsule each day	#28	
Ribavirin				
Sovaldi 400mg		Take one tablet each day	#28	
Viekira Pak		Two ombitasvir, paritaprevir, ritonavir 12.5/75/50mg tablets once daily (in the morning) and one dasabuvir 250 mg tablet twice daily (morning and evening) with a meal.	#112	
Daklinza 60mg		Take one tablet each day	#28	
Epclusa 400/100mg		Take one tablet each day	#28	
Zepatier 50/100		Take one tablet each day	#28	

My signature below authorizes Value Specialty Pharmacy staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Value Specialty Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said processes.

PRODUCT SUBSTITUTION PERMITTED	DATE	DISPENSE AS WRITTEN