



Hepatitis C Enrollment Form

Date: _____

Patient Data

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs kg
 SSN #: XXX-XX-____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Primary Language: _____
 Authorized Contact: _____ Contact's Phone: _____

Ins. Data

Primary Insurance: _____ Secondary Insurance: _____
 ID: _____ Group#: _____ ID: _____ Group#: _____

Clinical Information

Please include hard copies of: genotype, viral load, fibrosis testing, CBC, CMP, PT/INR, H&P, HBV & HIV Screening, NS5A resistance testing, and pertinent office visit notes to expedite prior authorization process

Diagnosis: B18.2 Chronic Viral HCV Other: _____ HIV Coinfected: Yes No HBV Coinfected: Yes No

Genotype: 1a 1b 2 3 4 6 Viral Load: _____ IU/ml Fibrosis Score: F0 F1 F2 F3 F4

Cirrhosis: Yes No Compensated Liver Disease: Yes No Decompensated Liver Disease: Yes No

Previous treatment history: Naïve Relapsed Partial Responder Null

Date(s) of previous therapy and medications: _____

Liver Transplant Status: Awaiting Status-post N/A Is patient currently on PPI therapy? Yes No

Prescription

Medication	Directions	Quantity	Refills/Duration
<input type="checkbox"/> Epclusa® 400/100mg	Take one tablet once daily	#28	
<input type="checkbox"/> Harvoni® 90/400mg	Take one tablet once daily	#28	
<input type="checkbox"/> Mavyret™ 100/40mg	Take 3 tablets orally once daily with food	#84	
<input type="checkbox"/> Olysio® 150mg	Take one tablet once daily	#28	
<input type="checkbox"/> Ribavirin® 200mg (weight based dosing)	<input type="checkbox"/> Take 400mg orally in the morning and in the evening <input type="checkbox"/> Take 400mg orally in the morning and 600mg orally in the evening <input type="checkbox"/> Take 600mg orally in the morning and in the evening <input type="checkbox"/> Take 600mg orally in the morning and 800mg orally in the evening		
<input type="checkbox"/> Sovaldi® 400mg	Take one tablet once daily	#28	
<input type="checkbox"/> Technivie®	Take two tablets in the morning with a meal	#56	
<input type="checkbox"/> Viekira Pak®	Take per individual dose pack as instructed twice daily	#112	
<input type="checkbox"/> Viekira XR®	Take 3 tablets (1 pack) daily with meal	#84	
<input type="checkbox"/> Vosevi™ 400/100/100mg	Take one tablet orally once daily with food	#28	
<input type="checkbox"/> Zepatier® 50/100mg	Take one tablet once daily	#28	

Is patient new to this therapy: YES NO | Ship to: Patient Office Other | Desired Start Date: _____

Prescriber Data

Prescribers Name: _____ DEA#: _____ NPI: _____
 Practice Name: _____ Contact: _____
 Address: _____ Phone: _____ Fax: _____
 City: _____ State: _____ Zip: _____ Key Contact#: _____

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 process.

Physician Signature: _____ Date: _____ This prescription will be filled generically unless prescriber writes "DAW" in the box to the right.

fax referral to: **844-812-6227** | phone: **855-265-8008** | **www.vsprx.com**