



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: _____
 Alternate Caregiver Name: _____ Phone of Caregiver: _____

Ins. Data

Primary Insurance: _____ Secondary Insurance: _____
 Policy: _____ Group#: _____ Policy: _____ 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 authorization process.

Diagnosis: B18.2 Chronic Viral HCV Other: _____ HIV Coinfected: Yes No HBV Coinfected: Yes No
 Genotype: 1a 1b 2 3 4 5 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: Naive 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 Sofosbuvir/Velpatasvir 400/100mg	Take one tablet orally once daily	#28	
<input type="checkbox"/> Harvoni® 90/400mg Ledipasvir/Sofosbuvir 90/400mg	Take one tablet orally once daily	#28	
<input type="checkbox"/> Mavyret™ 100/40MG	Take 3 tablets orally once daily with food	#84	
<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 orally once daily	#28	
<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 orally once daily	#28	

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

Prescriber Data

Prescriber 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