



# Hepatitis C Enrollment Form

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.