Hepatitis C Enrollment Form

CORNERSTONE Health Solutions

Fax Referral Form To: 1-781-805-8245
Specialty Pharmacy Phone: 1-844-319-7588

Please fill out the following 6 areas to submit a referral:

❶ PATIENT INFORMATION

Patient Name		Date of Birth
Address		Primary Phone
City	State	Alternate Phone
ZIP	Gender M F	Email
Primary Language		

❷ PRESCRIBER INFORMATION

Prescriber's Name	License #
DEA #	NPI #
Group or Hospital Name	Contact Person
Address	Phone
City, State, ZIP	Fax

❸ INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with applicable pre-authorization approvals with this form, if available.

❹ DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____

First Fill Ship to: ☐ **Patient** OR ☐ **Medical Office** OR ☐ **Other:** _____
Refills Shipped to: ☐ **Patient** OR ☐ **Medical Office** OR ☐ **Other:** _____

Diagnosis (ICD-10):
☐ B17.10 Acute Hepatitis C without Hepatic Coma ☐ B17.11 Acute Hepatitis C with hepatic coma ☐ B18.2 Chronic Hepatitis C
☐ B18.2 Unspecified Viral Hepatitis C without Hepatic Coma ☐ B20 HIV
☐ Other Code: _____ Description: _____ Viral Load: _____ Viral Load Date: _____

Patient Clinical Information: Height: _____ in/cm Weight: _____ lb/kg Allergies: _____
HCV Genotype: ☐ 1a ☐ 1b ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 AND ☐ No Cirrhosis ☐ Compensated Cirrhosis ☐ Decompensated Cirrhosis
Is patient: ☐ Treatment Naïve ☐ Partial Responder ☐ Non-Responder ☐ Relapser; Last Date of Therapy: _____ Tx : _____

❺ PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Daklinza™** (daclatasvir)	☐ 30 mg tablets ☐ 60 mg tablets ☐ 90 mg tablets	☐ Take one 60 mg tablet orally once a day ☐ Take one 90 mg tablet orally once a day ☐ Other: _____	28-day supply	☐ 12 weeks ☐ Other: _____
☐ **Epclusa®** (sofosbuvir / velpatasvir)	Fixed-dose combination tablet of 400 mg sofosbuvir and 100 mg velpatasvir	Take one tablet once daily.	28-day supply	☐ 12 weeks ☐ Other: _____
☐ **Harvoni®** (ledipasvir / sofosbuvir)	Fixed-dose combination tablet of 90 mg ledipasvir / 400mg sofosbuvir	Take orally once daily with or without food. Do not take within 4 hours of antacids.	28-day supply	☐ 8 weeks ☐ 12 weeks ☐ 24 weeks
☐ **Mavyret™** (glecaprevir and pibrentasvir)	Fixed-dose combination tablet of 100 mg glecaprevir and 40 mg pibrentasvir	Take three tablets orally once a day with food.	28-day supply	☐ 8 weeks ☐ 12 weeks ☐ Other: _____
☐ **Olysio®** (simeprevir)	150 mg capsule	Take one 150 mg capsule orally once a day.	28-day supply	☐ 12 weeks ☐ 24 weeks
☐ **PEGASYS®** (peginterferon alfa-2a)	☐ 180 mcg / 0.5mL ProClick™ Autoinjector ☐ Other: _____	☐ Inject 180 mcg subQ once a week as directed. ☐ Other: _____		
☐ **Ribavirin**	☐ 200 mg tablets ☐ 200 mg capsules	Take _____ tabs/caps orally QAM and _____ tabs/caps QPM for a total of _____ mg daily with food.		
☐ **Ribasphere® RibaPak®**	☐ 600 / 600 mg ☐ 400 / 400 mg ☐ 600 / 400 mg ☐ 200 / 400 mg	Take _____ tabs/caps orally QAM and _____ tabs/caps QPM for a total of _____ mg daily with food.		
☐ **Sovaldi®** (sofosbuvir)	400 mg tablets	Take one 400 mg tablet orally once a day.	28-day supply	
☐ **Technivie™** (ombitasvir / partiaprevir / ritonavir)	Fixed-dose combination tablet of 12.5 mg ombitasvir / 75 mg partiaprevir / 50 mg ritonavir	Take two tablets once daily in the morning.	28-day supply	
☐ **Viekira Pak™** (ombitasvir / partiaprevir / ritonavir tabs and dasabuvir tabs)	Copackaged 12.5 mg ombitasvir / 75 mg partiaprevir / 50 mg ritonavir and 250 mg dasabuvir	Take 2 pink tablets (ombitasvir / partiaprevir / ritonavir) once daily (morning) and 1 beige tablet (dasabuvir) twice daily (morning and evening) with meals.	28-day supply	☐ 12 weeks ☐ 24 weeks
☐ **Viekira XR™** (dasabuvir, ombitasvir, partiaprevir, ritonavir)		Take three tablets orally once a day with food.	28-day supply	☐ 12 weeks ☐ 24 weeks
☐ **VOSEVI™** (sofosbuvir, velpatasvir, and voxilaprevir)		Take one tablet orally once a day with food.	28-day supply	☐ 12 weeks ☐ Other: _____
☐ **Zepatier®** (elbasvir / grazoprevir)		Take one tablet once daily with or without food.	28-day supply	☐ 12 weeks ☐ 16 weeks

❻ STAMP SIGNATURE NOT ALLOWED

X PRESCRIBER SIGNATURE REQU

PRODUCT SUBSTITUTION PERMITTED **Date**

X

DISPENSE AS WRITTEN, NO SUBSTITUTION **Date**

Interchange is mandated unless the prescriber indicates "No Substitution" in accordance with the law