



Hepatitis C Enrollment Form

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:

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

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

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

4 DIAGNOSIS AND CLINICAL INFORMATION	
Needs by Date: _____	First Fill Ship to: <input type="checkbox"/> Patient <u>OR</u> <input type="checkbox"/> Medical Office <u>OR</u> <input type="checkbox"/> Other: _____ Refills Shipped to: <input type="checkbox"/> Patient <u>OR</u> <input type="checkbox"/> Medical Office <u>OR</u> <input type="checkbox"/> Other: _____
Diagnosis (ICD-10): <input type="checkbox"/> B17.10 Acute Hepatitis C without Hepatic Coma <input type="checkbox"/> B17.11 Acute Hepatitis C with hepatic coma <input type="checkbox"/> B18.2 Chronic Hepatitis C <input type="checkbox"/> B18.2 Unspecified Viral Hepatitis C without Hepatic Coma <input type="checkbox"/> B20 HIV <input type="checkbox"/> Other Code: _____ Description: _____ Viral Load: _____ Viral Load Date: _____	
Patient Clinical Information: Height: _____ in/cm Weight: _____ lb/kg Allergies: _____ HCV Genotype: <input type="checkbox"/> 1a <input type="checkbox"/> 1b <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 AND <input type="checkbox"/> No Cirrhosis <input type="checkbox"/> Compensated Cirrhosis <input type="checkbox"/> Decompensated Cirrhosis Is patient: <input type="checkbox"/> Treatment Naïve <input type="checkbox"/> Partial Responder <input type="checkbox"/> Non-Responder <input type="checkbox"/> Relapser; Last Date of Therapy: _____ Tx : _____	

5 PRESCRIPTION INFORMATION				
Medication	Dose/Strength	Directions	Quantity	Refills
<input type="checkbox"/> Daklinza™ (daclatasvir)	<input type="checkbox"/> 30 mg tablets <input type="checkbox"/> 60 mg tablets <input type="checkbox"/> 90 mg tablets	<input type="checkbox"/> Take one 60 mg tablet orally once a day <input type="checkbox"/> Take one 90 mg tablet orally once a day <input type="checkbox"/> Other: _____	28-day supply	<input type="checkbox"/> 12 weeks <input type="checkbox"/> Other: _____
<input type="checkbox"/> Epclusa® (sofosbuvir / velpatasvir)	Fixed-dose combination tablet of 400 mg sofosbuvir and 100 mg velpatasvir	Take one tablet once daily.	28-day supply	<input type="checkbox"/> 12 weeks <input type="checkbox"/> Other: _____
<input type="checkbox"/> 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	<input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks
<input type="checkbox"/> 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	<input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> Other: _____
<input type="checkbox"/> Olysio® (simeprevir)	150 mg capsule	Take one 150 mg capsule orally once a day.	28-day supply	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks
<input type="checkbox"/> PEGASYS® (peginterferon alfa-2a)	<input type="checkbox"/> 180 mcg / 0.5mL ProClick™ Autoinjector <input type="checkbox"/> Other: _____	<input type="checkbox"/> Inject 180 mcg subQ once a week as directed. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Ribavirin	<input type="checkbox"/> 200 mg tablets <input type="checkbox"/> 200 mg capsules	Take _____ tabs/caps orally QAM and _____ tabs/caps QPM for a total of _____ mg daily with food.		
<input type="checkbox"/> Ribasphere® RibaPak®	<input type="checkbox"/> 600 / 600 mg <input type="checkbox"/> 400 / 400 mg <input type="checkbox"/> 600 / 400 mg <input type="checkbox"/> 200 / 400 mg	Take _____ tabs/caps orally QAM and _____ tabs/caps QPM for a total of _____ mg daily with food.		
<input type="checkbox"/> Sovaldi® (sofosbuvir)	400 mg tablets	Take one 400 mg tablet orally once a day.	28-day supply	
<input type="checkbox"/> Technivie™ (ombitasvir / paritaprevir / ritonavir)	Fixed-dose combination tablet of 12.5 mg ombitasvir / 75 mg paritaprevir / 50 mg ritonavir	Take two tablets once daily in the morning.	28-day supply	
<input type="checkbox"/> Viekira Pak™ (ombitasvir / paritaprevir / ritonavir tabs and dasabuvir tabs)	Copackaged 12.5 mg ombitasvir / 75 mg paritaprevir / 50 mg ritonavir and 250 mg dasabuvir	Take 2 pink tablets (ombitasvir / paritaprevir / ritonavir) once daily (morning) and 1 beige tablet (dasabuvir) twice daily (morning and evening) with meals.	28-day supply	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks
<input type="checkbox"/> Viekira XR™ (dasabuvir, ombitasvir, paritaprevir, ritonavir)		Take three tablets orally once a day with food.	28-day supply	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks
<input type="checkbox"/> VOSEVI™ (sofosbuvir, velpatasvir, and voxilaprevir)		Take one tablet orally once a day with food.	28-day supply	<input type="checkbox"/> 12 weeks <input type="checkbox"/> Other: _____
<input type="checkbox"/> Zepatier® (elbasvir / grazoprevir)		Take one tablet once daily with or without food.	28-day supply	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 16 weeks

6 STAMP SIGNATURE NOT ALLOWED	
X _____ PRODUCT SUBSTITUTION PERMITTED	X _____ DISPENSE AS WRITTEN, NO SUBSTITUTION
Date _____	Date _____
Interchange is mandated unless the prescriber indicates "No Substitution" in accordance with the law	

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