

HEPATITIS C VIRUS SPECIALTY CARE PROGRAM

Phone: **833-796-6470** • Fax: **844-841-3401**

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: M F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Diagnostic Information

Date of Diagnosis: _____ ICD-10: _____ Race: _____
Genotype: _____ Subtype: _____ Q80K: Positive Negative (For Genotype 1a)
Indicate Patient Status: Naive Partial Responder Non-responder Null-responder Relapser
Duration of Previous Therapy: _____ Weeks From: _____ To: _____
Cirrhosis: No Yes If Yes: Compensated Decompensated
History of Liver Biopsy? No Yes If Yes, Please Attach Results
 Fibrosure or Fibroscan: Results: _____
Extra-Hepatic Manifestations: Ascites Hepatic Encephalopathy Thrombocytopenia
 Other: _____ Does the patient need liver transplantation? Yes No
HBsAg and anti-HBc Test: Positive Negative Date: _____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

Labs

ALT: _____ HGB: _____
AST: _____ HCV RNA: _____
PLT: _____ SrCr: _____
NS5A Resistance Assay: _____ Date: _____

Medication List and Contraindications

Attach Medication List
Is the patient interferon ineligible? No Yes
 Anxiety Depression Pulmonary Abnormalities
 Renal Insufficiency Other: _____

4 INJECTION TRAINING: To Be Administered by Pharmacist (State of Missouri Only) Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

5 PICK UP OR DELIVERY: Delivery to Patient's Home Delivery to Physician's Office Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION: Duration of Therapy: 8 Weeks 12 Weeks 24 Weeks Other _____
Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> DAKLINZA™	<input type="checkbox"/> 30mg Tablets <input type="checkbox"/> 60mg Tablets <input type="checkbox"/> 90mg Tablets	<input type="checkbox"/> Take 30mg daily with or without food in combination with Sovaldi® with or without Ribavirin <input type="checkbox"/> Take 60mg daily with or without food in combination with Sovaldi® with or without Ribavirin <input type="checkbox"/> Take 90mg daily with or without food in combination with Sovaldi® with or without Ribavirin	28 28 28	
<input type="checkbox"/> EPCLUSA®	<input type="checkbox"/> 400/100mg Tablets	<input type="checkbox"/> Take one tablet daily with or without food	28	
<input type="checkbox"/> HARVONI®	<input type="checkbox"/> 90/400mg Tablets	<input type="checkbox"/> Take one tablet daily with or without food	28	
<input type="checkbox"/> MAVYRET™	<input type="checkbox"/> 100/40mg Tablet	<input type="checkbox"/> Take three tablets orally once daily with food	1 Carton	
<input type="checkbox"/> OLYSIO®	<input type="checkbox"/> 150mg Capsules	<input type="checkbox"/> Take one 150mg capsule orally once a day	28	
<input type="checkbox"/> SOVALDI®	<input type="checkbox"/> 400mg Tablets	<input type="checkbox"/> Take one 400mg tablet orally once a day	28	
<input type="checkbox"/> VOSEVI®	<input type="checkbox"/> 400/100/100mg Tablets	<input type="checkbox"/> Take one tablet orally once daily with food	28	
<input type="checkbox"/> MODERIBA Dose Pack™ <input type="checkbox"/> RIBASPHERE Riba Pack®	<input type="checkbox"/> 600mg per day <input type="checkbox"/> 800mg per day <input type="checkbox"/> 1000mg per day <input type="checkbox"/> 1200mg per day	<input type="checkbox"/> Take 200mg tablet every morning/400mg tablet every evening <input type="checkbox"/> Take 400mg tablet every morning/400mg tablet every evening <input type="checkbox"/> Take 600mg tablet every morning/400mg tablet every evening <input type="checkbox"/> Take 600mg tablet every morning/600mg tablet every evening		
<input type="checkbox"/> MODERIBA™ <input type="checkbox"/> RIBASPHERE® <input type="checkbox"/> RIBAVIRIN	<input type="checkbox"/> 200mg Tablets <input type="checkbox"/> 200mg Capsules	<input type="checkbox"/> Take _____ tablets/capsules every morning and, <input type="checkbox"/> Take _____ tablets/capsules every evening		
<input type="checkbox"/> XIFAXAN®	<input type="checkbox"/> 550mg Tablets	<input type="checkbox"/> Take one tablet twice daily with or without food	60	
<input type="checkbox"/> ZEPATIER®	<input type="checkbox"/> 50/100mg Tablets	<input type="checkbox"/> Take one tablet daily with or without food	28	
<input type="checkbox"/> _____	_____	_____		

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.
Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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