HEPATITIS C PRESCRIPTION FORM http://www.newportlidopharmacy.com/

PATIENT INFORMATION	PRESCRIBER INFORMATION	
Patient Name:	Prescriber Name:	Today's Date:
Date of Birth: Gender: M / F	DEA: NPI:	Need By Date:
SSN:	Address:	**Ship To:**
Address:	City, State, ZIP Code:	☐ Patient
City, State, ZIP Code:	Phone: Fax:	☐ _____
Phone:	Contact Person:	

CLINICAL INFORMATION / ICD-10 CODE (Complete entire section or fax lab report including Genotype/Subtype)

Primary ICD-10 Code: _____

Genotype: _____ Subtype: _____ Viral Load: _____

Previous treated with Interferon: ☐ No ☐ Yes _____# of weeks

☐ Relapsed Partial ☐ Response ☐ Null Response

Liver Biopsy Done? ☐ No ☐ Yes, Result: _____

Lab	Result	Date
HCV RNA		
ALT		
AST		
Hgb		

MEDICATION	STRENGTH	DIRECTIONS	QTY / REFILLS
☐ **Harvoni** (ledipasvir/sofosbuvir)	90mg/400mg	☐ Take 1 tablet by mouth daily, with or without food.	28 Tab Refills: 1 2 3 4 5 _____
☐ **Epclusa** (sofosbuvir/velpatasvir)	400mg/100mg	☐ Take 1 tablet by mouth daily, with or without food.	28 Tab Refills: 1 2 3 4 5 _____
☐ **Ribavirin**	200mg	☐ Take _____ mg AM and _____ mg PM.	Qty: _____ Refills: 1 2 3 4 5 _____
☐ **Sovaldi**	400mg	☐ Take 1 tablet by mouth daily, with or without food.	28 Tab Refills: 1 2 3 4 5 _____
☐ **Viekira XR** (ombitasvir, paritaprevir, ritonavir, dasabuvir tablets)	8.33/50/33.33/200mg	☐ Take all 3 tablets at the same time once daily with a meal.	84 Tab (28 days supply) Refills: 1 2 3 4 5 _____
☐ **Zepatier** (elbasvir/grazprevir)	50mg/100mg	☐ Take 1 tablet by mouth daily, with or without food.	28 Tab Refills: 1 2 3 4 5 _____
☐ **Daklinza** (daclatasvir)	☐ 30mg ☐ 90mg ☐ 60mg	☐ Take 1 tablet by mouth daily, with or without food in combination with sofosbuvir.	28 Tab Refills: 1 2 3 4 5 _____

Recommended Treatment Regiment in Patients with Genotype 1, 2, 3, 4, 5, or 6 HCV

Patient Population	*Treatment Regiment and Duration*
Patients w/o cirrhosis and patients w/ compensated cirrhosis (Child-Pugh A)	Epclusa 12 wks
Patients with decompensated cirrhosis (Child-Pugh B or C)	Epclusa + ribavirin 12 wks

Genotype 1 or 4	Sovaldi + Reg-Interferon Alfa + Ribavirin		12 wks
Genotype 2	Sovaldi + Ribavirin		12 wks
Genotype 3	Sovaldi + Ribavirin		12 wks
Genotype 1 (Ineligible for Interferon)		Sovaldi + Ribavirin	24 wks
Hepatocellular Carcinoma Awaiting Liver Transplantation		Sovaldi + Ribavirin	48 wks

Genotype 1a	without cirrhosis	Viekira XR + Ribavirin	12 wks
Genotype 1a	with cirrhosis	Viekira XR + Ribavirin	24 wks
Genotype 1b	without cirrhosis	Viekira XR	12 wks
Genotype 1b	with cirrhosis	Viekira XR	12 wks

PRESCRIPTION INSURANCE INFORMATION		PATIENT BILLING INFORMATION	
Insurance Plan Type:	Rx Bin:	Credit Card:	Visa, Mastercard, American Express, Other
Processor Control No. or PCN (if available):		Credit Card Number:	
Identification Number:		CVV (last 3-digits):	
Rx Group:		Expiration Date (mm/yy):	

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to Newport Lido Pharmacy to act as the prescriber's agent to begin and execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature: _____ **Date:** _____ ☐ **Do Not Substitute**

NEWPORT LIDO PHARMACY

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