evers SPECIALTY PHARMACY & Infusion Services

Hepatitis C/HCV

Prescription/Pharmacy Intake Form

Rx FAX: 718-323-9377 **Rx Phone: 718-323-8377**

Provider Representative | **Phone** **Date Needed** **Ship to** ☐ Specialty Care Center ☐ Patient's Home ☐ Prescriber's Office ☐ Other_____

PATIENT INFORMATION

Patient Name: _____ DOB: _____ ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Phone # (Daytime): _____ Phone # (Evening): _____

E-mail Address: _____

Insurance Provider (**Please include copy of front and back of card**): _____

ID #: _____ Policy/Group #: _____ Phone #: _____

Name of Insured: _____ Employer: _____

Relationship to Patient: ☐ Self ☐ Other: _____ ☐ Patient is Eligible for Medicare

Prescription Card: ☐ Yes ☐ No Carrier: _____ Policy/Group #: _____

CLINICAL ASSESSMENT

☐ Patient is Naive
☐ Patient is a Null Responder
☐ Patient is a Relapser

Primary Diagnosis Code: _____

Current Weight: _____ Date: _____

Height (pediatrics): _____ Date: _____

Genotype: ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
☐ Positive for Q80K Polymorphism

Initial Viral Load: _____ IU/mL

Date of Initial Viral Load: _____

Previous Treatment: ☐ No
☐ Yes, with _____

Fibrosis Score: _____ ☐ Cirrhosis
☐ Decompensated

Other Health Conditions: _____

_____

Allergies: _____

_____

Concomitant Medications: _____

_____

_____

PRESCRIPTION INFORMATION

Medication	Directions/Freq	Qty	Refills
Harvoni® ☐ 90mg/400mg tablets			
Olysio™ ☐ 150 mg capsules			
Sovaldi® ☐ 400 mg tablets			
Victrelis® ☐ 200 mg capsules			
Viekira Pak™ ☐ 12.5/75/50mg and 250mg tablets			
☐ **Moderiba™** ☐ 200 mg tablets ☐ **Ribasphere®** ☐ 200 mg capsules			
☐ **Moderiba™ Dose Pack** ☐ **Ribasphere® Ribapak®** ☐ 600mg/day = 200-400: 200 mg AM/400 mg PM ☐ 800 mg/day = 400-400: 400 mg AM/400 mg PM ☐ 1,000 mg/day = 600-400: 600 mg AM/400 mg PM ☐ 1,200 mg/day = 600-600: 600 mg AM/600 mg PM			
Ribavirin ☐ 200 mg tablets ☐ 200 mg capsules			
Pegasys® ☐ 180 mcg/0.5 mL prefilled syringe 4 pack ☐ 180 mcg/1 mL vial ☐ 135 mcg/0.5mL ProClick™ - 4 autoinjectors ☐ 180 mcg/0.5 mL ProClick™ - 4 autoinjectors			
PegIntron® ☐ 50 mcg/0.5 mL ☐ 80 mcg/0.5 mL ☐ 120 mcg/0.5 mL ☐ 150 mcg/0.5 mL ☐ Vial ☐ Redipen: 1 pack ☐ Redipen: 4 pack			
☐ Aranesp® ☐ Neulasta® ☐ Procrit® ☐ _____ ☐ Granix™ ☐ Neupogen® ☐ Promacta® ☐ _____			

PRESCRIBER INFORMATION

Prescriber's Name: _____ Practice/Facility Name: _____

Address: _____ Office Contact: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax: _____ Best Time to Call: _____

State License #: _____ DEA #: _____ NPI#: _____ Medicaid UPIN #: _____

In order for a brand name product to be dispensed, the prescriber must handwrite "**Brand Necessary**" or "**Brand Medically Necessary**," or your state specific required language to prohibit substitution: _____

I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature Required: _____ Date: _____

Secondary Signature Optional: _____ Date: _____