



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

## 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: \_\_\_\_\_

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.

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Drug names are the property of their respective owners.

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