

Hepatitis C Enrollment Form



Telephone: 1-888-216-6553; 443-707-6300

Fax: 1-888-216-6802; 410-728-5116

Website: <https://totalhealthcarerx.org>

1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name: _____ DOB: _____

Address: _____ City, State, ZIP Code: _____

Gender: ☐ Male ☐ Female

Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)

Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____ Alternate Phone: _____

If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____

Relationship to minor: _____

Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____

NPI #: _____ DEA #: _____ Group or Hospital: _____

Address: _____ City, State, ZIP Code: _____

Phone: _____ Fax: _____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

Diagnosis (ICD-10):

☐ B17.10 Acute Hepatitis C without hepatic coma

☐ B18.2 Chronic Hepatitis C

☐ B20 HIV

☐ B17.11 Acute Hepatitis C with hepatic coma

☐ B19.20 Unspecified Viral Hepatitis C without hepatic coma

☐ Other Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____ Weight: _____ lb/kg Height: _____ in/cm

HCV Genotype: ☐ 1a ☐ 1b ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 AND ☐ No Cirrhosis ☐ Compensated Cirrhosis ☐ Decompensated Cirrhosis

Is patient: ☐ Naïve ☐ Partial Responder ☐ Non-Responder ☐ Relapser; Last Date of Therapy: _____ Product Name(s): _____

Is patient currently on Hepatitis C Virus therapy? ☐ No ☐ Yes, Therapy Start Date: _____ Product Name(s): _____

Is patient post-liver transplant? ☐ Yes ☐ No For Zepatier genotype 1a patients, NS5A polymorphism present? ☐ Yes ☐ No

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Epclusa Tablet (sofosbuvir and velpatasvir)	Fixed-dose combination tablet of 400 mg sofosbuvir / 100 mg velpatasvir	Take one tablet once daily.	Quantity: _____ Refills: _____
<input type="checkbox"/> Epclusa Oral Pellets (sofosbuvir and velpatasvir)	<input type="checkbox"/> Unit-dose pellet packets of 200 mg sofosbuvir and 50 mg velpatasvir <input type="checkbox"/> Unit-dose pellet packets of 150 mg sofosbuvir and 37.5 mg velpatasvir	_____ kg / lb (please circle) <input type="checkbox"/> Mix _____ packet(s) of oral pellets with a small amount of soft food and swallow once daily <input type="checkbox"/> Pour _____ packet(s) of oral pellets directly into the mouth and swallow once daily <input type="checkbox"/> Other: _____	Quantity: 28-day supply Refills: <input type="checkbox"/> 12 weeks <input type="checkbox"/> Other: _____
<input type="checkbox"/> Harvoni (ledipasvir and sofosbuvir)	Fixed-dose combination tablet of 90 mg ledipasvir / 400 mg sofosbuvir	Take PO once daily with or without food. Do not take within 4 hours of antacids.	Quantity: 28-day supply Refills: <input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks

☐ Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

<p>"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute</p> <p>Prescriber's Signature: _____ Date: _____</p>	<p>May Substitute / Product Selection Permitted / Substitution Permissible</p> <p>Prescriber's Signature: _____ Date: _____</p>
<p>CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" _____ ATTN: New York and Iowa providers, please submit electronic prescription</p>	

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize Total Health Care Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature. Page 1 of 2

Hepatitis C Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____
 Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Mavyret Tablet (glecaprevir and pibrentasvir)	Fixed-dose combination tablet of 100 mg glecaprevir and 40 mg pibrentasvir	Take three tablets PO once a day with food.	Quantity: 28-day supply Refills: <input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> Other _____
<input type="checkbox"/> Mavyret Oral Pellets (glecaprevir and pibrentasvir)	Unit-dose pellet packets of 50 mg glecaprevir and 20 mg pibrentasvir	_____ kg / lb (please circle) <input type="checkbox"/> Mix _____ packet(s) of oral pellets with a small amount of soft food and swallow once daily <input type="checkbox"/> Other: _____	Quantity: 28-day supply Refills: <input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> Other _____
<input type="checkbox"/> Ribavirin	<input type="checkbox"/> 200 mg tablets <input type="checkbox"/> 200 mg capsules	Take _____ tabs/caps PO q am and _____ tabs/caps q pm for a total of _____ mg daily with food.	Quantity: _____ Refills: _____
<input type="checkbox"/> Sovaldi (sofosbuvir)	<input type="checkbox"/> 400 mg tablets	Take one 400 mg tablet PO once a day.	Quantity: 28-day supply Refills: _____
<input type="checkbox"/> Vosevi (sofosbuvir, velpatasvir, and voxilaprevir)	Fixed-dose combination tablet of 400 mg sofosbuvir / 100 mg velpatasvir/100 mg voxilaprevir	Take one tablet PO once a day with food.	Quantity: 28-day supply Refills: <input type="checkbox"/> 12 weeks <input type="checkbox"/> Other _____
<input type="checkbox"/> Zepatier (elbasvir and grazoprevir)	Zepatier (elbasvir/grazoprevir)	Take one tablet once daily with or without food.	Quantity: 28-day supply Refills: <input type="checkbox"/> 12 weeks <input type="checkbox"/> 16 weeks

☐ Patient is interested in patient support programs

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