Hepatitis C Enrollment Form

Medford Chemists

2608 Route 112, Medford, NY 11763| Email: info@medfordchemists.com | Phone: 1-855-MEDCHEM| Fax: 631-475-4476

PATIENT INFORMATION

Name:	Date of Birth:		O Male O Female
Address:	City:	State:	Zip:
Phone:	Alt Phone:		Primary Language:
SS #:	Patient Email:		SSN:

PRESCRIBER INFORMATION

Prescribing Practitioner:				NPI#:
Supervising Physician:				NPI#:
Address:	City:	State:	Zip:	Tax ID:
Phone:	Fax:			Office Contact:

MEDICAL INFORMATION

** PLEASE FAX COPY OF PRESCRIPTION MEDICATION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY **

Date of Diagnosis: ___/____/______
B18.2 HCV (Chronic): Genotype: ________
*If Genotype 1a, is Q80K polymorphism present? ☐ Yes ☐ No
*If Genotype 1a, is NS5A Resistance-Associated polymorphism present?
☐ Yes ☐ No
Other: ____

Treatment Naïve? ☐ Yes ☐ No
Previously treated with Interferon?
☐ Yes ☐ No (☐ Relapsed ☐ Partial ☐ Null)
Cirrhosis? ☐ Yes ☐ No (If yes, is it: ☐ compensated ☐ decompensated)
Metavir: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4

Allergies:

Height: __________________ in/cm Weight: __________________ kg/lbs

LAB VALUES

Name of Value	Value	Date	Name of Value	Value	Date
Base Viral Load			Genotype		
Cirrhosis			Metavir Score		
Fibro scan	kPA		Sustained Virologic Response		

PRESCRIPTION INFORMATION

Needs by Date: **Ship to:** ☐ **Patients home** ☐ **Prescriber 1st order only** ☐ **Prescriber all orders** ☐ **Other**

Drug	Dose	Direction & Quantities	Qty/Refills
☐ **Epclusa®**	400/100mg Tablet (sofosbuvir/velpatasvir)	Take 1 tablet by mouth daily with or without food (Quantity: 28)	Qty: _________ Refills: _________
☐ **Harvoni®**	400/90mg Tablet (ledipasvir/sofosbuvir)	Take 1 tablet by mouth daily with or without food (Quantity: 28)	Qty: _________ Refills: _________
☐ **Mavyret™**	100/40mg Tablet (glecaprevir/pibrentasvir.)	Take 3 tablets by mouth daily with food (Quantity: 84)	Qty: _________ Refills: _________
☐ **Sovaldi™**	400mg Tablet	Take 1 tablet by mouth daily with or without food (Quantity: 28) *Maximum of 2 additional refills for Genotypes 1, 2, and 4* *Maximum of 5 additional refills for Genotype 3*	Qty: _________ Refills: _________
☐ **Vosevi™**	400/100/100mg Tablets (sofosbuvir, velpatasvir, voxilaprevir)	Take 1 tablet by mouth daily with food (Quantity: 28)	Qty: _________ Refills: _________
☐ **Zepatier™**	50mg/100mg Tablet (elbasvir/grazoprevir)	Take 1 tablet by mouth daily with or without food (Quantity: 28)	Qty: _________ Refills: _________
☐ **Other:**			Qty: _________ Refills: _________

PRESCRIBING PRACTITIONER SIGNATURE

Prescribing Practitioner: 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 this form and utilizing our services, you are also authorizing Medford Chemists Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

☐ **DAW Brand Medically Necessary** ☐ **May substitute/ Substitution Permissible**

Prescribing Practitioner: **Date**

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