

# HEPATITIS C VIRUS SPECIALTY CARE PROGRAM

Phone: **844-MILLRX-0** • Fax: **844-468-7606**

## 1 PATIENT INFORMATION:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
DOB: \_\_\_\_\_ Gender:  M  F Caregiver: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Allergies: \_\_\_\_\_

## 2 PRESCRIBER INFORMATION:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
NPI: \_\_\_\_\_ DEA: \_\_\_\_\_  
Tax I.D.: \_\_\_\_\_  
Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

## 3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

**Diagnostic Information**

Date of Diagnosis: \_\_\_\_\_ ICD-10: \_\_\_\_\_ Race: \_\_\_\_\_  
Genotype: \_\_\_\_\_ Subtype: \_\_\_\_\_ Q80K:  Positive  Negative (For Genotype 1a)  
Indicate Patient Status:  Naive  Partial Responder  Non-responder  Null-responder  Relapser  
Duration of Previous Therapy: \_\_\_\_\_ Weeks From: \_\_\_\_\_ To: \_\_\_\_\_  
Cirrhosis:  No  Yes If Yes:  Compensated  Decompensated  
History of Liver Biopsy?  No  Yes If Yes, Please Attach Results  
 Fibrosure or  Fibroscan: Results: \_\_\_\_\_  
Extra-Hepatic Manifestations:  Ascites  Hepatic Encephalopathy  Thrombocytopenia  
 Other: \_\_\_\_\_ Does the patient need liver transplantation?  Yes  No  
HBsAg and anti-HBc Test:  Positive  Negative Date: \_\_\_\_\_

**Labs**

ALT: \_\_\_\_\_ HGB: \_\_\_\_\_  
AST: \_\_\_\_\_ HCV RNA: \_\_\_\_\_  
PLT: \_\_\_\_\_ SrCr: \_\_\_\_\_  
NS5A Resistance Assay: \_\_\_\_\_ Date: \_\_\_\_\_

**Medication List and Contraindications**

Attach Medication List  
Is the patient interferon ineligible?  No  Yes  
 Anxiety  Depression  Pulmonary Abnormalities  
 Renal Insufficiency  Other: \_\_\_\_\_

**If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.**

**4 INJECTION TRAINING:**  To Be Administered by Pharmacist  Pharmacist to Provide Training  Patient Trained in MD Office  Manufacturer Nurse Support

**5 PICK UP OR DELIVERY:**  Delivery to Patient's Home  Delivery to Physician's Office  Pharmacy to Coordinate

**6 INSURANCE INFORMATION:** Please Include Front and Back Copies of Pharmacy and Medical Card

**PRESCRIPTION:** Duration of Therapy:  8 Weeks  12 Weeks  24 Weeks  Other \_\_\_\_\_  
Patient Name: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> DAKLINZA™	<input type="checkbox"/> 30mg Tablets <input type="checkbox"/> 60mg Tablets <input type="checkbox"/> 90mg Tablets	<input type="checkbox"/> Take 30mg daily with or without food in combination with Sovaldi® with or without Ribavirin <input type="checkbox"/> Take 60mg daily with or without food in combination with Sovaldi® with or without Ribavirin <input type="checkbox"/> Take 90mg daily with or without food in combination with Sovaldi® with or without Ribavirin	28 28 28	
<input type="checkbox"/> EPCLUSA®	<input type="checkbox"/> 400/100mg Tablets	<input type="checkbox"/> Take one tablet daily with or without food	28	
<input type="checkbox"/> HARVONI®	<input type="checkbox"/> 90/400mg Tablets	<input type="checkbox"/> Take one tablet daily with or without food	28	
<input type="checkbox"/> MAVYRET™	<input type="checkbox"/> 100/40mg Tablet	<input type="checkbox"/> Take three tablets orally once daily with food	1 Carton	
<input type="checkbox"/> OLYSIO®	<input type="checkbox"/> 150mg Capsules	<input type="checkbox"/> Take one 150mg capsule orally once a day	28	
<input type="checkbox"/> SOVALDI®	<input type="checkbox"/> 400mg Tablets	<input type="checkbox"/> Take one 400mg tablet orally once a day	28	
<input type="checkbox"/> VOSEVI®	<input type="checkbox"/> 400/100/100mg Tablets	<input type="checkbox"/> Take one tablet orally once daily with food	28	
<input type="checkbox"/> MODERIBA Dose Pack™ <input type="checkbox"/> RIBASPHERE Riba Pack®	<input type="checkbox"/> 600mg per day <input type="checkbox"/> 800mg per day <input type="checkbox"/> 1000mg per day <input type="checkbox"/> 1200mg per day	<input type="checkbox"/> Take 200mg tablet every morning/400mg tablet every evening <input type="checkbox"/> Take 400mg tablet every morning/400mg tablet every evening <input type="checkbox"/> Take 600mg tablet every morning/400mg tablet every evening <input type="checkbox"/> Take 600mg tablet every morning/600mg tablet every evening		
<input type="checkbox"/> MODERIBA™ <input type="checkbox"/> RIBASPHERE® <input type="checkbox"/> RIBAVIRIN	<input type="checkbox"/> 200mg Tablets <input type="checkbox"/> 200mg Capsules	<input type="checkbox"/> Take _____ tablets/capsules every morning and, <input type="checkbox"/> Take _____ tablets/capsules every evening		
<input type="checkbox"/> XIFAXAN®	<input type="checkbox"/> 550mg Tablets	<input type="checkbox"/> Take one tablet twice daily with or without food	60	
<input type="checkbox"/> ZEPATIER®	<input type="checkbox"/> 50/100mg Tablets	<input type="checkbox"/> Take one tablet daily with or without food	28	
<input type="checkbox"/> _____	_____	_____		

**PRESCRIBER SIGNATURE:** I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Substitution Permitted**

**Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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