Bell Pharmacy

Hepatitis C Enrollment Form

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PATIENT INFORMATION

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

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: ___/____/_____

O B18.2 HCV (Chronic): Genotype: _____

*If Genotype 1a, is Q80K polymorphism present? O Yes O No

*If Genotype 1a, is NS5A Resistance-Associated polymorphism present?

O Yes O No

O Other: _____

Treatment Naïve? O Yes O No

Previously treated with Interferon?

O Yes O No (O Relapsed O Partial O Null)

Cirrhosis? O Yes O No (If yes, is it: O compensated O decompensated)

Metavir: O F0 O F1 O F2 O F3 O 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		
Fibroscan	kPA		Sustained Virologic Response		

PRESCRIPTION INFORMATION

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

Drug	Dose	Direction & Quantities	Duration
O Epclusa®	400/100mg Tablet (sofosbuvir/velpatasvir)	Take 1 tablet PO QD with or without food (Quantity: 28)	O 12 weeks
O Harvoni®	400/90mg Tablet (ledipasvir/sofosbuvir)	Take 1 tablet PO QD with or without food (Quantity: 28)	O 8 weeks O 12 weeks
O Mavyret ™	100/40mg Tablet (glecaprevir/pibrentasvir.)	Take 3 tablets PO QD with food (Quantity: 84)	O 8 weeks O 12 weeks
O Olysio™	150mg Capsule	Take 1 capsule PO QD with food (Quantity: 28) *Maximum of 2 additional refills*	O 8 weeks O 12 weeks
O Sovaldi™	400mg Tablet	Take 1 tablet PO QD 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*	O 8 weeks O 12 weeks
O Viekira XR™	8.33/50/33.33/200mg Tablets (ombitasvir, paritaprevir, ritonavir, dasabuvir)	Take 3 tablets PO QD with a meal (Quantity: 84)	O 8 weeks O 12 weeks
O Vosevi™	400/100/100mg Tablets (sofosbuvir, velpatasvir, voxilaprevir)	Take 1 tablet PO QD with food (Quantity: 28)	O 8 weeks O 12 weeks
O Zepatier™	50mg/100mg Tablet (elbasvir/grazoprevir)	Take 1 tablet PO QD with or without food (Quantity: 28)	O 8 weeks O 12 weeks
O Other:			

PRESCRIBING PRACTITIONER SIGNATURE

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

Prescribing Practitioner: Date

CONFIDENTIALITY NOTICE

Faxed Prescriptions will only be accepted from a prescribing practitioner.