Hepatitis C Virus

Patient Information

Patient name: ______________________________ DOB: __________
Sex: ❑ Female ❑ Male SSN: _______________ Ethnicity: _______________
Language: ________________ Wt: ______ ❑ kg ❑ lbs Ht: ______ ❑ cm ❑ in
Address: ____
Apt/Suite: ________ City: _________________ State: _______ Zip: _______
Phone: _________________________ Alternate: _______________________
Caregiver name: ___________________________ Relation: _____________
Local pharmacy: __________________________ Phone: _______________
Insurance plan: ____________________ Plan ID: ______________________

Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: ____
NPI: ____
Address: ____
Apt/Suite: _______ City: _______________ State: ________ Zip: _______
Contact: ____
Phone:_____________________ Alternate: _____________________
Fax: ____
Email: ____
If shipping to prescriber: ❑ First Fill ❑ Always Never

Clinical Information (Please fax pertinent clinical and lab information)

Diagnosis: ❑ B18.2 (Chronic Hepatitis C Virus) Diagnosis date: __________
Genotype: ❑1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 Subtype: ❑ A ❑ B ❑ A/B ❑ N/A
Baseline viral load: ______________________ Date: _________________
Degree of fibrosis: ❑ F0 ❑ F1 ❑ F2 ❑ F3 ❑ F4 ❑ ________________
Cirrhosis: ❑ None ❑ Compensated ❑ Decompensated (CTP: ❑ B ❑ C)
Co-infection(s): ❑ None ❑ HIV ❑ HBV

Transplant status: ❑ N/A ❑ Pre-transplant ❑ Post-transplant
sCr: ____________ GFR: _________________ Date: ___________
CKD stage: 1 2 3 4 5 N/A Dialysis: Yes No
IL28B polymorphism: CC CT TT
Q80K polymorphism: ❑ Yes ❑ No NS5A polymorphism: ❑ Yes ❑ No
NS5A polymorphism type: ❑ M28 ❑ Q30 ❑ L31 ❑ Y93 ❑ _________

Prior Regimen ❑ Naïve ❑ Experienced (List below)	Start Date	End Date	Treatment Weeks	Response*
________________________	__________	__________	__________	❑IC ❑ NR ❑ PR ❑ RLP
________________________	__________	__________	__________	❑IC ❑ NR ❑ PR ❑ RLP
________________________	__________	__________	__________	❑IC ❑ NR ❑ PR ❑ RLP

**Response definitions: IC – Incomplete treatment, NR – Null Responder, PR – Partial Response, RLP - Relapser*

Comorbidities: ____
Concomitant Medications: ____
Allergies: ❑ NKDA ❑ Other: ____

Prescription

Prescription		Quantity	Duration	Refill
❑ **Daklinza®** **(daclatasvir)**	❑ Take 30 mg by mouth once daily ❑ Take 60 mg by mouth once daily ❑ Take 90 mg by mouth once daily	❑ 28 x 30 mg tablets ❑ 28 x 60 mg tablets ❑ 28 x 90 mg tablets	❑ 12 weeks ❑ 24 weeks	_____
❑ **Epclusa®** **(velpatasvir/sofosbuvir)**	❑ Take 100 mg/400 mg by mouth once daily	❑ 28 x 100 mg/400 mg tablets	❑ 12 weeks 24 weeks	_____
❑ **Harvoni®** **(ledipasvir/sofosbuvir)**	❑ Take 90 mg/400 mg by mouth once daily	❑ 28 x 90 mg/400 mg tablets	❑ 8 weeks ❑ 12 weeks ❑ 24 weeks	_____
❑ **Olysio®** **(simeprevir)**	❑ Take 150 mg by mouth once daily	❑ 28 x 150 mg capsules	❑ 12 weeks ❑ 24 weeks	_____
❑ **Sovaldi®** **(sofosbuvir)**	❑ Take 400 mg by mouth once daily	❑ 28 x 400 mg tablets	❑ 12 weeks ❑ 24 weeks	_____
❑ **Technivie™** **(ombitasvir/paritaprevir/ritonavir)**	❑ Take 2 tablets by mouth in the morning with food	❑ 56 x 12.5 mg/75 mg/50 mg tablets	❑ 12 weeks ❑ 24 weeks	_____
❑ **Viekira Pak®** **(dasabuvir/ombitasvir/paritaprevir/ritonavir)**	❑ Take 3 tablets by mouth in the morning and 1 tablet by mouth in the evening with food	❑ 112 x 250 mg/12.5 mg/75 mg/50 mg tablets	❑ 12 weeks ❑ 24 weeks	_____
❑ **Viekira XR™** **(dasabuvir/ombitasvir/paritaprevir/ritonavir)**	❑ Take 3 tablets by mouth once daily with food	❑ 84 x 200 mg/8.33 mg/50 mg/ 33.33 mg tablets		
❑ **Zepatier™** **(elbasvir/grazoprevir)**	❑ Take 50 mg/100 mg by mouth once daily	❑ 28 x 50/100 mg tablets	❑ 12 weeks ❑ 16 weeks	_____
❑ **Pegasys®** **(peginterferon alfa-2a)**	❑ Inject 180 mcg subcut once weekly ❑ ______________________________	❑ 4 x 180 mcg	❑ PFS ❑ Autoinjector	_____
❑ **Ribasphere® Ribapak® Dose Pak** **(ribavirin)** ❑ **Moderiba™ Dose Pack** **(ribavirin)**	❑ Take _________ mg tablet by mouth every morning, ________ mg tablet by mouth every evening (________ mg/day)	❑ 28 x 200 mg; 28 x 400 mg ❑ 28 x 400 mg; 28 x 400 mg ❑ 28 x 400 mg; 28 x 600 mg ❑ 28 x 600 mg; 28 x 600 mg	Tablets	_____
❑ **Ribasphere®**** **(ribavirin)**	❑ Take _________ mg tablet by mouth every morning, ________ mg tablet by mouth every evening (________ mg/day)	❑ _____ x 200 mg	❑ Tablets ❑ Capsules	_____

***For the form (tablets or capsules), unless otherwise specified, pharmacy preference/availiability (or insurance preference) will be dispensed.*

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: ______________________

Stamp signature not allowed, physician signature required.

Prescriber's Signature:____ Date: _______________

I authorize Diplomat Pharmacy, Inc. and its representatives to act as an agent to initiate and execute the insurance prior authorization and appeal process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Diplomat Pharmacy, Inc.

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