

# Hepatitis C Virus



Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____ Ethnicity: _____ Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate: _____ Caregiver name: _____ Relation: _____ Local pharmacy: _____ Phone: _____ Insurance plan: _____ Plan ID: _____ <b>Please fax a copy of front and back of the insurance card(s).</b>	Prescriber name: _____ NPI: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email: _____ If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

Clinical Information (Please fax pertinent clinical and lab information)				
Diagnosis: <input type="checkbox"/> B18.2 (Chronic Hepatitis C Virus) Diagnosis date: _____ Genotype: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 Subtype: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> A/B <input type="checkbox"/> N/A Baseline viral load: _____ Date: _____ Degree of fibrosis: <input type="checkbox"/> F0 <input type="checkbox"/> F1 <input type="checkbox"/> F2 <input type="checkbox"/> F3 <input type="checkbox"/> F4 _____ Cirrhosis: <input type="checkbox"/> None <input type="checkbox"/> Compensated <input type="checkbox"/> Decompensated (CTP: <input type="checkbox"/> B <input type="checkbox"/> C) Co-infection(s): <input type="checkbox"/> None <input type="checkbox"/> HIV <input type="checkbox"/> HBV		Transplant status: <input type="checkbox"/> N/A <input type="checkbox"/> Pre-transplant <input type="checkbox"/> Post-transplant sCr: _____ GFR: _____ Date: _____ CKD stage: 1 2 3 4 5 N/A Dialysis: Yes No IL28B polymorphism: CC CT TT Q80K polymorphism: <input type="checkbox"/> Yes <input type="checkbox"/> No NS5A polymorphism: <input type="checkbox"/> Yes <input type="checkbox"/> No NS5A polymorphism type: <input type="checkbox"/> M28 <input type="checkbox"/> Q30 <input type="checkbox"/> L31 <input type="checkbox"/> Y93 _____		
Prior Regimen <input type="checkbox"/> Naïve <input type="checkbox"/> Experienced (List below)	Start Date	End Date	Treatment Weeks	Response* <input type="checkbox"/> IC <input type="checkbox"/> NR <input type="checkbox"/> PR <input type="checkbox"/> RLP <input type="checkbox"/> IC <input type="checkbox"/> NR <input type="checkbox"/> PR <input type="checkbox"/> RLP <input type="checkbox"/> IC <input type="checkbox"/> NR <input type="checkbox"/> PR <input type="checkbox"/> RLP
_____	_____	_____	_____	_____
*Response definitions: IC – Incomplete treatment, NR – Null Responder, PR – Partial Response, RLP - Relapser				
Comorbidities: _____ Concomitant Medications: _____ Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____				

Prescription	Quantity	Duration	Refill
<input type="checkbox"/> <b>Daklinza®</b> (daclatasvir)	<input type="checkbox"/> Take 30 mg by mouth once daily <input type="checkbox"/> Take 60 mg by mouth once daily <input type="checkbox"/> Take 90 mg by mouth once daily	<input type="checkbox"/> 28 x 30 mg tablets <input type="checkbox"/> 28 x 60 mg tablets <input type="checkbox"/> 28 x 90 mg tablets	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks
<input type="checkbox"/> <b>Epclusa®</b> (velpatasvir/sofosbuvir)	<input type="checkbox"/> Take 100 mg/400 mg by mouth once daily	<input type="checkbox"/> 28 x 100 mg/400 mg tablets	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks
<input type="checkbox"/> <b>Harvoni®</b> (ledipasvir/sofosbuvir)	<input type="checkbox"/> Take 90 mg/400 mg by mouth once daily	<input type="checkbox"/> 28 x 90 mg/400 mg tablets	<input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks
<input type="checkbox"/> <b>Mavyret™</b> (glecaprevir + pibrentasvir)	<input type="checkbox"/> Take 3 tablets by mouth once daily with food	<input type="checkbox"/> 84 x 100 mg/40 mg tablets	<input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> 16 weeks
<input type="checkbox"/> <b>Olysio®</b> (simeprevir)	<input type="checkbox"/> Take 150 mg by mouth once daily	<input type="checkbox"/> 28 x 150 mg capsules	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks
<input type="checkbox"/> <b>Sovaldi®</b> (sofosbuvir)	<input type="checkbox"/> Take 400 mg by mouth once daily	<input type="checkbox"/> 28 x 400 mg tablets	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks
<input type="checkbox"/> <b>Technivie™</b> (ombitasvir/paritaprevir/ritonavir)	<input type="checkbox"/> Take 2 tablets by mouth in the morning with food	<input type="checkbox"/> 56 x 12.5 mg/75 mg/50 mg tablets	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks
<input type="checkbox"/> <b>Viekira Pak®</b> (dasabuvir/ombitasvir/paritaprevir/ritonavir)	<input type="checkbox"/> Take 3 tablets by mouth in the morning and 1 tablet by mouth in the evening with food	<input type="checkbox"/> 112 x 250 mg/12.5 mg/75 mg/50 mg tablets	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks
<input type="checkbox"/> <b>Viekira XR™</b> (dasabuvir/ombitasvir/paritaprevir/ritonavir)	<input type="checkbox"/> Take 3 tablets by mouth once daily with food	<input type="checkbox"/> 84 x 200 mg/8.33 mg/50 mg/33.33 mg tablets	_____
<input type="checkbox"/> <b>Vosevi™</b> (sofosbuvir/velpatasvir/voxilaprevir)	Take 1 tablet by mouth once daily with food	28 x 400 mg/100 mg tablets	12 weeks
<input type="checkbox"/> <b>Zepatier™</b> (elbasvir/grazoprevir)	<input type="checkbox"/> Take 50 mg/100 mg by mouth once daily	<input type="checkbox"/> 28 x 50/100 mg tablets	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 16 weeks
<input type="checkbox"/> <b>Ribasphere® Ribapak® Dose Pak</b> (ribavirin) <input type="checkbox"/> <b>Moderiba™ Dose Pack</b> (ribavirin)	<input type="checkbox"/> Take _____ mg tablet by mouth every morning, _____ mg tablet by mouth every evening ( _____ mg/day)	<input type="checkbox"/> 28 x 200 mg; 28 x 400 mg <input type="checkbox"/> 28 x 400 mg; 28 x 400 mg <input type="checkbox"/> 28 x 400 mg; 28 x 600 mg <input type="checkbox"/> 28 x 600 mg; 28 x 600 mg	Tablets _____
<input type="checkbox"/> <b>Ribasphere®**</b> (ribavirin)	<input type="checkbox"/> Take _____ mg tablet by mouth every morning, _____ mg tablet by mouth every evening ( _____ mg/day)	<input type="checkbox"/> _____ x 200 mg	<input type="checkbox"/> Tablets <input type="checkbox"/> Capsules _____

\*\*For the form (tablets or capsules), unless otherwise specified, pharmacy preference/availability (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.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 810.768.9178 or by emailing compliance@diplomat.is to obtain instructions as to the proper destruction of the transmitted material. Thank you.

Copyright © 2017 by Diplomat Pharmacy Inc. All rights reserved. Diplomat is a registered trademark of Diplomat Pharmacy Inc. 08082017