

Hepatitis C Enrollment Form

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PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name _____ Date of Birth _____ <input type="radio"/> Male <input type="radio"/> Female Street Address _____ Apt # _____ City _____ State _____ Zip _____ Phone-Primary _____ Secondary _____ <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Other _____ Email Address _____ Social Security # _____ <input type="radio"/> NKDA Known Drug Allergies _____ Weight _____ kg/lb Height _____ in/cm <p style="color: blue; text-align: center;">Please attach front and back of patient's insurance cards</p>	Prescriber Name _____ NPI _____ License # _____ Office Contact _____ Street Address _____ Ste # _____ City _____ State _____ Zip _____ Phone _____ Fax _____ By signing this form, I authorize Maxor Specialty to act as my agent for prior authorizations & prescription reimbursement for the above listed patient. Physician Signature _____ Date _____ <input type="radio"/> Dispense as written <input type="radio"/> Product substitution permitted <p style="text-align: center;">** For Ohio patients, please only choose one (1) prescription/form.**</p>

CLINICAL INFORMATION
<input type="radio"/> B18.2 Chronic Hepatitis C <input type="radio"/> K72.90 <input type="radio"/> K72.91 Hepatic Encephalopathy <input type="radio"/> C22.0 <input type="radio"/> C22.2 <input type="radio"/> C22.7 <input type="radio"/> C22.8 Hepatocellular Carcinoma <input type="radio"/> Other _____ Genotype: _____ NS5A RAVs <input type="radio"/> Yes <input type="radio"/> No Viral load: _____ IU/ml Viral load date: _____ <input type="radio"/> Treatment naïve <input type="radio"/> Previously treated: Prior treatment used: _____ <input type="radio"/> Non-responder <input type="radio"/> Responder/Relapser Duration of previous therapy: From _____ to _____ Total of: _____ months HIV Coinfected: <input type="radio"/> Yes <input type="radio"/> No HBV Coinfected: <input type="radio"/> Yes <input type="radio"/> No Compensated Liver Disease: <input type="radio"/> Yes <input type="radio"/> No Cirrhosis: <input type="radio"/> Yes <input type="radio"/> No Metavir Score: _____ Solid Organ Transplant recipient: <input type="radio"/> Yes <input type="radio"/> No Awaiting liver transplant: <input type="radio"/> Yes <input type="radio"/> No

PRESCRIPTION INFORMATION	CHECK TO ENROLL IN PATIENT ASSISTANCE PROGRAM <input type="radio"/>
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MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
<input type="radio"/> Daklinza™ (daclatasvir)	<input type="radio"/> 30mg <input type="radio"/> 60mg <input type="radio"/> 90mg	Take one tablet PO QD with or without food *Must be taken in combination with sofosbuvir	28 day supply	
<input type="radio"/> Harvoni® (ledipasvir/sofosbuvir)	90/400mg tablet	Take one tablet PO QD with or without food <input type="radio"/> Naïve without cirrhosis who have a pretreatment HCV RNA <6 million IU/ml; 8 wks <input type="radio"/> Naïve with or without cirrhosis; 12 wks <input type="radio"/> Experienced without cirrhosis; 12 wks <input type="radio"/> Experienced with cirrhosis; 24 wks	28 day supply	
<input type="radio"/> Olysio® (simeprevir)	150mg capsule	Take 150mg (1 capsule) PO QD with food *Monotherapy not recommended	28 day supply	
<input type="radio"/> Riba-pak®	<input type="radio"/> 600mg <input type="radio"/> 800mg <input type="radio"/> 1000mg <input type="radio"/> 1200mg	<input type="radio"/> 200mg every morning, 400mg every evening <input type="radio"/> 400mg every morning, 400mg every evening <input type="radio"/> 600mg every morning, 400mg every evening <input type="radio"/> 600mg every morning, 600mg every evening	28 day supply	
<input type="radio"/> Ribasphere®	200mg		28 day supply	
<input type="radio"/> Sovaldi® (sofosbuvir)	400mg tablet	Take 400mg (1 tablet) PO QD with or without food *Monotherapy not recommended	28 day supply	
<input type="radio"/> Technivie™ (ombitasvir/paritaprevir/ritonavir)	12.5/75/50mg	Take two fixed dose combination tablets daily in the morning *Must be taken with ribavirin	28 day supply	
<input type="radio"/> Viekira Pak® (ombitasvir/paritaprevir/ritonavir/dasabuvir)	12.5/75/50/250mg	Take one dose pack daily with food as directed <input type="radio"/> Genotype 1a without cirrhosis Viekira Pak + ribavirin; 12 wks <input type="radio"/> Genotype 1a with cirrhosis Viekira Pak + ribavirin; 24 wks** <input type="radio"/> Genotype 1b without cirrhosis Viekira Pak; 12 wks <input type="radio"/> Genotype 1b with cirrhosis Viekira Pak; 12 wks (may be given with or without ribavirin) Notes: Follow the genotype 1a dosing recommendations in patients with an unknown genotype 1 subtype or with mixed genotype infection **For liver transplant recipients, the recommended duration of Viekira Pak + ribavirin is 24 wks	28 day supply	
<input type="radio"/> Zepatier™ (elbasvir/grazoprevir)	50/100mg tablet	Take one tablet PO QD with or without food; 12 wks Genotype 1a NS5A resistance-associated polymorphisms are present, administer with ribavirin and extend therapy to 16 wks	28 day supply	

Date meds needed: _____ New Refill
 Ship to: Patient's home Physician's Office Other _____

CONFIDENTIALITY NOTICE: This communication is intended for and should be delivered to the individual or entity to which it is addressed and contains information that is privileged, confidential and exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute or copy this information. Please notify the sender immediately if you have received this document in error.