

Hepatitis C Virus



Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____	Prescriber name: _____
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____ Ethnicity: _____	NPI: _____
Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in	Address: _____
Address: _____	Apt/Suite: _____ City: _____ State: _____ Zip: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____	Contact: _____
Phone: _____ Alternate: _____	Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____	Fax: _____
Local pharmacy: _____ Phone: _____	Email: _____
Insurance plan: _____ Plan ID: _____	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: _____	Transplant status: <input type="checkbox"/> N/A <input type="checkbox"/> Pre-transplant <input type="checkbox"/> Post-transplant
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	sCr: _____ GFR: _____ Date: _____
Baseline viral load: _____ Date: _____	CKD stage: 1 2 3 4 5 N/A Dialysis: Yes No
Degree of fibrosis: <input type="checkbox"/> F0 <input type="checkbox"/> F1 <input type="checkbox"/> F2 <input type="checkbox"/> F3 <input type="checkbox"/> F4 <input type="checkbox"/> _____	IL28B polymorphism: CC CT TT
Cirrhosis: <input type="checkbox"/> None <input type="checkbox"/> Compensated <input type="checkbox"/> Decompensated (CTP: <input type="checkbox"/> B <input type="checkbox"/> C)	Q80K polymorphism: <input type="checkbox"/> Yes <input type="checkbox"/> No NS5A polymorphism: <input type="checkbox"/> Yes <input type="checkbox"/> No
Co-infection(s): <input type="checkbox"/> None <input type="checkbox"/> HIV <input type="checkbox"/> HBV	NS5A polymorphism type: <input type="checkbox"/> M28 <input type="checkbox"/> Q30 <input type="checkbox"/> L31 <input type="checkbox"/> Y93 <input type="checkbox"/> _____

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: NKDA Other: _____

Prescription	Quantity	Duration	Refill
<input type="checkbox"/> Daklinza® (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"/> Epclusa® (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"/> Harvoni® (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"/> Olysio® (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"/> Sovaldi® (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"/> Technivie™ (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"/> Viekira Pak® (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"/> Viekira XR™ (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"/> 24 weeks
<input type="checkbox"/> Zepatier™ (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"/> Pegasys® (peginterferon alfa-2a)	<input type="checkbox"/> Inject 180 mcg subcut once weekly <input type="checkbox"/> _____	<input type="checkbox"/> 4 x 180 mcg	<input type="checkbox"/> PFS <input type="checkbox"/> Autoinjector
<input type="checkbox"/> Ribasphere® Ribapak® Dose Pak (ribavirin) <input type="checkbox"/> Moderiba™ Dose Pack (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"/> Ribasphere®** (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.

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