

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: _____ Please fax a copy of front and back of the insurance card(s).	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 <input type="checkbox"/> _____ 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 <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
*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: _____				
Expected Duration of Therapy: 8 weeks 12 weeks 16 weeks 24 weeks				

Prescription	Quantity	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"/> 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"/> 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"/> Mavyret™ (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"/> Olysio® (simeprevir)	<input type="checkbox"/> Take 150 mg by mouth once daily	<input type="checkbox"/> 28 x 150 mg capsules
<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"/> Technivie™ (ombitasvir/paritaprevir/ritonavir)	<input type="checkbox"/> Take 2 tablets by mouth in the morning with food	56 x 12.5 mg/75 mg/50 mg tablets
<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"/> 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"/> Vosevi™ (sofosbuvir/velpatasvir/voxilaprevir)	<input type="checkbox"/> Take 1 tablet by mouth once daily with food	<input type="checkbox"/> 28 x 400 mg/100 mg/100 mg tablets
<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"/> 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 tablets <input type="checkbox"/> 28 x 400 mg; 28 x 400 mg tablets <input type="checkbox"/> 28 x 400 mg; 28 x 600 mg tablets <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 tablets <input type="checkbox"/> _____ x 200 mg 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: _____

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.