Prescription & Enrollment Form
Hepatitis C

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient first name ______
Last name ______ Middle initial ______
Date of birth ______ ❑ Male ❑ Female Last 4 digits of SSN ______
Street address ______ Apt # ______
City ______ State ______ Zip ______
Parent/guardian (if applicable) ______
Home phone ______ Work phone ______
Cell phone ______ Evening phone ______
E-mail address ______
Patient's primary language: ❑ English ❑ Other If other, please specify ______

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company ______ Phone ______
Insured's name ______
Insured's employer ______ Relationship to patient ______
Identification # ______ Policy/group # ______
Prescription card: ❑ Yes ❑ No If yes, carrier ______
Policy # ______ Group # ______
Is patient eligible for Medicare? ❑ Yes ❑ No
Does patient have a secondary insurance? ❑ Yes ❑ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date ______ Time ______
Prescriber's first name ______ Last name ______
Prescriber's title ______
If NP or PA, under direction of Dr. ______
Office contact and title ______
Office contact email ______
Office/clinic/institution name ______
Clinic/hospital affiliation ______
Street address ______ Suite # ______
City ______ State ______ Zip ______
Phone ______ Fax ______
NPI # ______ License # ______ MD specialty ______
❑ Send all shipments to MD office ❑ Send first fill to MD office

3 CLINICAL INFORMATION

Primary ICD-10 code ______
Comorbidities ______
❑ NKDA ❑ Known drug allergies ______
Current weight ______ kg/lbs Date recorded ______ Cirrhosis ❑ Yes ❑ No
HCV genotype: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ Subtype ______
What is the pre-treatment (baseline) HCV RNA level (viral load)? ______ IU/mL
Collection date ______
Has the patient been previously treated for hepatitis C? ❑ Yes ❑ No, naïve to treatment
If yes, name the product(s) and date range(s) of treatment and outcome (if applicable)
______
Responder status: ❑ Partial responder ❑ Null responder ❑ Relapser
Concurrent meds ______

4 PRESCRIBING INFORMATION

Medication	Strength / Formulation	Directions	Quantity/Refills
❑ Epclusa® (sofosbuvir/ velpatasvir)	400 mg sofosbuvir/100 mg velpatasvir tablet	Take one tablet daily with or without food. Duration: ❑ 12 weeks ❑ Other ______	❑ 1-month supply ❑ 3-month supply ❑ Other ______ Refills ______
❑ Harvoni® (ledipasvir/ sofosbuvir)	90 mg ledipasvir/400 mg sofosbuvir tablet	Take one tablet daily. Duration: ❑ 8 weeks ❑ 12 weeks ❑ 24 weeks ❑ Other ______	❑ 1-month supply ❑ 3-month supply ❑ Other ______ Refills ______
❑ Mavyret™ (glecaprevir/pibrentasvir)	100 mg glecaprevir/40 mg pibrentasvir tablet	Take 3 tablets once daily at same time with food. Duration: ❑ 8 weeks ❑ 12 weeks ❑ 16 weeks	❑ 1-month supply ❑ 3-month supply ❑ Other ______ Refills ______
❑ Ribavirin	❑ 200 mg tablet ❑ 200 mg capsule	Take ______ tabs/caps QAM and ______ tabs/caps QPM with food. ❑ Other ______	❑ 1-month supply ❑ 3-month supply ❑ Other ______ Refills ______
❑ Sovaldi® (sofosbuvir)	400 mg tablet	Take one (400 mg) tablet once daily. Duration: ❑ 12 weeks ❑ 24 weeks ❑ Other ______	❑ 1-month supply ❑ 3-month supply ❑ Other ______ Refills ______
❑ Viekira Pak® (ombitasvir, paritaprevir and ritonavir tablets; dasabuvir tablets)	Pak contains: ombitasvir, paritaprevir, ritonavir (pink tablets): 12.5/75/50 mg dasabuvir (beige tablets): 250 mg	❑ Take two ombitasvir, paritaprevir, ritonavir (pink) tablets once daily AM and one dasabuvir (beige) tablet twice daily AM and PM with a meal. ❑ Other ______ Duration: ❑ 12 weeks ❑ 24 weeks ❑ Other ______	❑ 1-month supply ❑ 3-month supply ❑ Other ______ Refills ______
❑ Vosevi™ (sofosbuvir/velpatasvir/ voxilaprevir)	400 mg sofosbuvir/100 mg velpatasvir/ 100 mg voxilaprevir tablet	Take one tablet daily with food. Select previous treatment experience if applicable: ❑ Previous use of NS5A ❑ Previous use of sofosbuvir without NS5A	❑ 1-month supply ❑ 3-month supply ❑ Other ______ Refills ______
❑ Zepatier™ (elbasvir/ grazoprevir)	50 mg elbasvir/100 mg grazoprevir tablet NS5A resistant polymorphisms: ❑ Yes ❑ No	❑ Take one tablet daily with or without food. ❑ Other ______ Duration: ❑ 12 weeks ❑ 24 weeks ❑ Other ______	❑ 1-month supply ❑ 3-month supply ❑ Other ______ Refills ______
❑ Other medication			❑ 1-month supply ❑ 3-month supply ❑ Other ______ Refills ______
❑ Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer the therapy		As needed for administration	Send quantity sufficient for medication days supply

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE REQUIRED

Date ______ Substitution allowed ______ Date ______ Dispense as written ______

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Please fax completed form to the Hep C team at 888.302.1028. To reach your team, call toll-free 888.608.9010.

You can now track shipments for all your Accredo patients. Go to https://prescribers.accredo.com and click "Help" to register.

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