



HEPATITIS C ENROLLMENT FORM

FAX REFERRAL TO: 1-888-801-0404
PHONE: 1-888-570-9077

Date: _____ • Ship to: Patient Office
 Needs by Date: _____

PATIENT INFORMATION

(Complete the following or send patient demographic sheet)

Name: _____
 Address _____
 City, State, Zip: _____
 Cell Phone: _____
 Home Phone: _____
 SS#: _____
 Date of Birth: _____
 Weight: _____ Height: _____ Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
 DEA #: _____ NPI #: _____
 Group/Hospital: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____ Fax _____
 Contact Person: _____

INSURANCE INFORMATION

Primary Insurance/Prescription Card:
 PLEASE FAX COPY OF INS CARD (front and back if available)
Secondary Insurance/Prescription Card:
 PLEASE FAX COPY OF INS CARD (front and back if available)

Hepatitis C Clinical Info

ICD 10 Codes
 B18.2 Chronic Viral Hepatitis C
 Other: _____
 Specify _____

Treatment Naïve? Yes No
 Liver Biopsy? Yes No
 Co-infected? HIV HBV
 Prior Treatment _____

Please Attach:

Fibrosure result:
 Liver Biopsy:
 Genotype result:
 Viral load results:
 Chart notes:
 Drug/Alcohol screen if completed

Viral Load _____ Date _____
 Genotype _____
 Treatment Duration _____

Prior Treatments:

Medication	Start Date	End date

PRESCRIPTION INFORMATION

MEDICATION	DOSE	FREQUENCY/DIRECTIONS FOR USE	QUANTITY	REFILLS
<input type="checkbox"/> Epclusa®	<input type="checkbox"/> 100mg /400mg tabs	<input type="checkbox"/> 1 tab once daily for 12 weeks (Child Pugh class A) <input type="checkbox"/> 1 tab once daily for 12 weeks + Ribavirin (Child Pugh class B,C)	<input type="checkbox"/> 12 weeks	
<input type="checkbox"/> Harvoni™	<input type="checkbox"/> 90mg/400mg tablets	<input type="checkbox"/> 1 tab po daily	<input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> 14 weeks	
<input type="checkbox"/> Viekira Pak™	<input type="checkbox"/> 28 day Pak	<input type="checkbox"/> Take 3 tablets in the morning with a meal, and 1 tablet in the evening with a meal as per instructions on dose pak	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks	
<input type="checkbox"/> Sovaldi™	<input type="checkbox"/> 400 mg tabs	<input type="checkbox"/> 400mg (1 tab) po once daily	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks	
<input type="checkbox"/> Daklinza™	<input type="checkbox"/> 60 mg tabs <input type="checkbox"/> 30 mg tabs	<input type="checkbox"/> 1 tab po once daily with Sovaldi for 12 weeks	<input type="checkbox"/> 12 weeks	
<input type="checkbox"/> Zepatier®	<input type="checkbox"/> 50mg/100 mg tabs	<input type="checkbox"/> Take 1 tablet po once daily *For Genotype 1a patients, please have NS5A testing done	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 16 weeks	
<input type="checkbox"/> Technivie™	<input type="checkbox"/> 12.5/75/50mg tabs	<input type="checkbox"/> 2 tabs once daily in the morning with food and Ribavirin for 12 weeks <input type="checkbox"/> 2 tabs once daily in the morning with food for 12 weeks (naïve & Ribavirin intolerant)	<input type="checkbox"/> 12 weeks	
<input type="checkbox"/> Ribavirin	<input type="checkbox"/> 200mg tabs <input type="checkbox"/> 200mg caps	<input type="checkbox"/> Take _____ mg p.o. qam & _____ mg po qpm With Food	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks	
<input type="checkbox"/> Other:				

I authorize Focus Rx staff or its representatives to act as an agent of prescriber to execute any prior authorization or appeal on my behalf.