HEPATITIS C ENROLLMENT FORM

FocusRx
Positive Patient Outcomes

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 _____

Viral Load _____Date_____

Genotype _____

Treatment Duration_____

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 ☐

Prior Treatments:

Medication	Start Date	End date

PRESCRIPTION INFORMATION

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

Prescriber Signature (Date)

☒ *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.*