Your Lifetime Pharmacy Solution

HEPATITIS C
ENROLLMENT FORM

Phone: 813-871-5161 Ext. 34993 **Fax: 813-877-2479**

PATIENT INFORMATION *(COMPLETE THE FOLLOWING OR ATTACH PATIENT DEMOGRAPHIC SHEET)*

Patient Name		☐ Male ☐ Female	Allergies
Date of Birth	SSN#		Patient Weight Height Date
Address	City	State	Zip
Phone # (Primary)	(Secondary)		Email address

INSURANCE INFORMATION *(COMPLETE THE FOLLOWING OR COPY AND ATTACH THE FRONT AND BACK OF INSURANCE AND PRESCRIPTION DRUG CARD)*

Primary Insurance		Policyholder
Group #	Policy #	Phone #
Secondary Insurance	Policy#	Phone #

DIAGNOSIS/CLINICAL INFORMATION *(PLEASE SEND RECENT CLINICAL NOTES, LABS, & CURRENT MEDICATIONS TO EXPIDITE THE PRIOR AUTHORIZATION)*

☐ B18.2 Hepatitis C (Chronic)	Genotype: ___________________	HCV/HBV viral load __________________IU/ml
☐ Other ICD-10 ___________________	HIV Co-Infection? ☐Yes ☐ No	Date of Last Labs_____/____/_____

Is patient: ☐Treatment Naïve ☐ Treatment Experienced

If treatment experienced, previous treatment received & date: ____

Liver Biopsy performed? ☐ Yes ☐ No **Fibrosure Performed** ☐ Yes ☐ No **Fibroscan Performed** ☐ Yes ☐ No _____ **KPa**

Fibrosis Score: _______________ **Is patient cirrhotic?** ☐ Yes ☐ No **If yes**, is patient: ☐ Compensated ☐ Decompensated

PRESCRIPTION INFORMATION *(COMPLETE DRUG THERAPY INFORAMTION OR ATTACH COMPLETED PRESCRTIPTION)*

Medication	Dose	Frequency	Quantity	Refills
☐ EPCLUSA® (sofosbuvir & velpatasvir)	☐ 400mg/100 mg tablet	☐ orally one time daily	28 day supply	
☐ MAVYRET™ (glecaprevir 100 mg & pibrentasvir 40 mg)	☐ 300mg/120 mg 3 tablet regimen	☐ orally one time daily with food	28 day supply	
☐ HARVONI® (ledipasvir & sofosbuvir)	☐ 90mg/400 mg tablet	☐ orally one time daily	28 day supply	
☐ VOSEVI™ (sofosbuvir 400 mg/velpatasvir 100 mg/voxilaprevir 100 mg)	☐ 400mg/100mg/100mg tablet	☐ orally one time daily with food	28 day supply	
☐ Ribavirin 200mg capsules or tablets	Take __________ PO in AM & __________ PO in PM		28 day supply	
☐ Other: _______________________	Dose: ____________________	Frequency: ______________		

DELIVERY INSTRUCTIONS

☐ **Provider's Office** ☐ **Patient's Home** ☐**1st dose to Provider's Office, refills to patient home**

PROVIDER CONTACT INFORMATION & AUTHORIZATION

Provider Name:	Office Contact:	Email:
Phone:	Fax:	Institution:
Address:		City:
License #	Tax ID:	NPI #

Provider's Signature ____ **Date** _______________

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

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