Hepatitis C Enrollment Form

RESTORE Rx SPECIALTY PHARMACY

Date: _____

Patient Data

Patient Name: _____ Birthdate: _____
Sex: ☐ Male ☐ Female Height: _____ Weight: _____ ○lbs ○kg
SSN #: XXX-XX-_____
Known Allergies: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Primary Language: _____
Authorized Contact: _____
Contact's Phone: _____

Ins. Data

Primary Insurance: _____
Secondary Insurance: _____
ID: _____ Group#: _____
ID: _____ Group#: _____

Clinical Information

Please include hard copies of: genotype, viral load, fibrosis testing, CBC, CMP, PT/INR, H&P, HBV & HIV Screening, NS5A resistance testing, and pertinent office visit notes to expedite prior authorization process.

Diagnosis: ☐ B18.2 Chronic Viral HCV ☐ Other: _____ **HIV Coinfected:** ☐Yes ☐No **HBV Coinfected:** ☐Yes ☐No

Genotype: 1a☐ 1b☐ 2☐ 3☐ 4☐ 6☐ **Viral Load:** _____ IU/ml **Fibrosis Score:** F0☐ F1☐ F2☐ F3☐ F4☐

Cirrhosis: ☐Yes ☐No **Compensated Liver Disease:** ☐Yes ☐No **Decompensated Liver Disease:** ☐Yes ☐No

Previous treatment history: ☐ Naïve ☐ Relapsed ☐ Partial Responder ☐ Null

Date(s) of previous therapy and medications: _____

Liver Transplant Status: ☐ Awaiting ☐ Status-post ☐ N/A **Is patient currently on PPI therapy?** ☐Yes ☐No

Prescription

Medication	Directions	Quantity	Refills/Duration
☐ Daklinza® 60mg	Take one tablet once daily	#28	
☐ Epclusa® 400/100mg	Take one tablet once daily	#28	
☐ Harvoni® 90/400mg	Take one tablet once daily	#28	
☐ Mavyret™ 100/40mg	Take 3 tablets orally once daily with food	#84	
☐ Olysio® 150mg	Take one tablet once daily	#28	
☐ Ribavirin® 200mg (weight based dosing)	☐ Take 400mg orally in the morning and in the evening ☐ Take 400mg orally in the morning and 600mg orally in the evening ☐ Take 600mg orally in the morning and in the evening ☐ Take 600mg orally in the morning and 800mg orally in the evening		
☐ Sovaldi® 400mg	Take one tablet once daily	#28	
☐ Technivie®	Take two tablets in the morning with a meal	#56	
☐ Viekira Pak®	Take per individual dose pack as instructed twice daily	#112	
☐ Viekira XR®	Take 3 tablets (1 pack) daily with meal	#84	
☐ Vosevi™ 400/100/100mg	Take one tablet orally once daily with food	#28	
☐ Zepatier® 50/100mg	Take one tablet once daily	#28	

Is patient new to this therapy? ☐ YES ☐ NO | **Ship to:** ☐ Patient ☐ Office ☐ Other | **Desired Start Date:** _____

Prescriber Data

Prescriber Name: _____
DEA#: _____ NPI: _____
Practice Name: _____
Contact: _____ Preferred Method: ☐ Phone ☐ Fax ☐ Email
Address: _____
Phone: _____ Fax: _____
City: _____ State: _____ Zip: _____
Email: _____

My signature below authorizes Restore Rx, Inc. staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Restore Rx, Inc. Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: _____ Date: _____

This prescription will be filled generically unless prescriber writes **"DAW"** in the box to the right.