Hepatitis C Enrollment Form

RESTORE Rx SPECIALTY PHARMACY

Patient Data

Patient Name: _____ Birthdate: _____
SSN #: XXX-XX-_____
Address: _____
Home Phone: _____ Cell Phone: _____
Alternate Caregiver Name: _____

Sex: ☐ Male ☐ Female Height: _____ Weight: _____ lbs☐ kg☐
Known Allergies: _____
City: _____ State: _____ Zip: _____
Primary Language: _____
Phone of Caregiver: _____

Ins. Data

Primary Insurance: _____
Policy: _____ Group#: _____

Secondary Insurance: _____
Policy: _____ 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 authorization process.

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

Genotype: ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 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: ☐ Naive ☐ 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
☐ Epclusa® 400/100mg *Sofosbuvir/Velpatasvir 400/100mg*	Take one tablet orally once daily	#28	
☐ Harvoni® 90/400mg *Ledipasvir/Sofosbuvir 90/400mg*	Take one tablet orally once daily	#28	
☐ Mavyret™ 100/40MG	Take 3 tablets orally once daily with food	#84	
☐ 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 orally once daily	#28	
☐ Vosevi™ 400/100/100mg	Take one tablet orally once daily with food	#28	
☐ Zepatier® 50/100mg	Take one tablet orally once daily	#28	

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

Prescriber Data

Prescriber Name: _____
Practice Name: _____
Address: _____
City: _____ State: _____ Zip: _____

DEA#: _____ NPI: _____
Contact: _____ Preferred Method: ☐ Phone ☐ Fax ☐ Email
Phone: _____ Fax: _____
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.