

<input type="checkbox"/> New to Therapy
<input type="checkbox"/> Current Therapy

Patient Information	Clinical Information and Prescription
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Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
**Please attach copy of front and back of patient's prescription ins. card(s) if applicable**  
 Insurance Company Name: \_\_\_\_\_  
 Insurance Company Phone: \_\_\_\_\_  
 Policy holder: \_\_\_\_\_  
 Policy holder Employer: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_  
 ID# \_\_\_\_\_ Group# \_\_\_\_\_  
 RxBIN: \_\_\_\_\_ RxPCN: \_\_\_\_\_

### Prescriber Information

Practice/ Organization Name: \_\_\_\_\_  
 Physician Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_  
 DEA# \_\_\_\_\_ NPI# \_\_\_\_\_  
 License#: \_\_\_\_\_ Medicaid UPIN#: \_\_\_\_\_  
 Physician Specialty: \_\_\_\_\_  
**Date Shipment Needed:** \_\_\_\_\_  
**Ship to:** Patient Prescriber Other: \_\_\_\_\_  
 Shipment Address: \_\_\_\_\_ Attn: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
*If shipped to the physician's office, physician accepts on behalf of patient for administration in office.*

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Diagnosis:  B18.2 Chronic Viral Hepatitis C  \_\_\_\_\_ Description: \_\_\_\_\_  
 Co-infection:  HIV  HBV Patient's Weight: \_\_\_\_\_ kg Hgb: \_\_\_\_\_ g/dL (RBV only)  
 Genotype:  1a  1b  2  3  4  5/6 HCV RNA level: \_\_\_\_\_ IU/ml Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Metavir Score: \_\_\_\_\_ Cirrhosis  Yes  No If yes,  Compensated or  Decompensated.  
 Child-Pugh score: \_\_\_\_\_ Post liver transplant:  Yes  No Renal impairment:  Yes  No  
 Previously treated for HCV?  Yes  No Prior treatment(s): \_\_\_\_\_  
 Treatment response:  Partial  Null  Intolerant (specify): \_\_\_\_\_  
 Concurrent medications: \_\_\_\_\_  
 Patients Allergies: \_\_\_\_\_  
 Expected First Dose Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ **Medical History -Please attach all lab/test results**

**Epclusa®** (400mg/100mg sofosbuvir/velpatasvir).  
**Take 1 tablet by mouth once daily with or without food for \_\_\_\_\_ weeks.**

**Harvoni®** (90mg/400mg ledipasvir/sofosbuvir).  
**Take 1 tablet by mouth once daily with or without food for \_\_\_\_\_ weeks.**

**Mavyret®** (100mg/40mg glecaprevir/pibrentasvir).  
**Take Three (3) tablets by mouth once daily with food for \_\_\_\_\_ weeks.**

**Sovaldi®** (400mg sofosbuvir).  
**Take 1 tablet by mouth once daily for \_\_\_\_\_ weeks.**

**Viekira Pak®** (250mg/12.5mg/75mg/50mg Dasabuvir/Ombitasvir/Paritaprevir/Ritonavir)  
**Take as directed on the Pak for 12 weeks.**

**Vosevi®** (400mg/100mg/100mg sofosbuvir/velpatasvir/voxilaprevir)  
**Take 1 tablet by mouth once daily with or without food for 12 weeks.**

**Zepatier™** (50mg/100mg elbasvir/grazprevir).  
**Take 1 tablet by mouth once daily for \_\_\_\_\_ weeks.**

**Ribavirin Rx:** \_\_\_\_\_

**Dispense: 28 day supply of medication with**  0  1  2  Other: \_\_\_\_\_ Refills

Prescriber Signature: X \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_