ENVISIONSPECIALTY

Hepatitis C Enrollment Form

Phone: 877-437-9012 Fax: 877-309-0687

☐ New to Therapy
☐ Current Therapy

Patient Information

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.

Clinical Information and Prescription

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: _____/_____/_____