Hepatitis C Enrollment Form

ABD Apothecary By Design
Reimagining Pharmacy Care, Inspired By You

PLEASE FAX TO: 207-899-0968
PHONE: 207-899-0939

PATIENT INFORMATION

Patient Name: **Date of Birth:** ☐ Male ☐ Female

Address:

Phone: **Alternate Phone:**

Height: **Weight:** **Insurance Information:** ☐ Attached

Allergies:

CLINICAL INFORMATION

Genotype: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 **Cirrhosis status:** ☐ Non-cirrhotic ☐ Compensated ☐ Decompensated

Subtype: ☐ a ☐ b **Metavir Score:** ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4

Treatment History: ☐ Treatment Naïve ☐ Prior Relapser ☐ Null Responder ☐ Partial Responder

Previous treatment with:

CLINICAL CHECKLIST

☐ **Viral Load**	☐ **CBC**
☐ **Genotype Lab**	☐ **Resistance Testing if Applicable**
☐ **CMP**	☐ **Chart Notes**
☐ **Liver Staging Documentation**	☐ **Copy of Insurance Card**
☐ **HBV Surface & Core Antibodies**	☐ *Commitment Letter, UDS (Requirement for some Medicaid plans)*

DRUG	DOSE/STRENGTH	DIRECTIONS	QTY	REF
☐ **Mavyret** (glecaprevir/pibrentasvir)	**100/40mg**	**Take 3 tablets by mouth once daily with food as directed on pack**	**84**	
☐ **Epclusa** (velpatasvir/sofosbuvir)	**100/400mg**	**Take 1 tablet by mouth once daily**	**28**	
☐ **Harvoni** (ledipasvir/sofosbuvir)	**90/400mg**	**Take 1 tablet by mouth once daily**	**28**	
☐ **Zepatier** (elbasvir/grazoprevir) ☐ *GT 1a, include NS5A polymorphism testing*	**50/100mg**	**Take 1 tablet by mouth once daily**	**28**	
☐ **Vosevi** (sofosbuvir/velpatasvir/voxilaprevir)	**400/100/100mg**	**Take 1 tablet by mouth once daily with food**	**28**	
☐ **Sovaldi** (sofosbuvir)	**400mg**	**Take 1 tablet by mouth once daily**	**28**	
☐ **Daklinza** (daclatasvir)	☐ **30mg** ☐ **60mg** ☐ **90mg**	**Take 1 tablet by mouth once daily**	**28**	
☐ **Ribavirin** **Weight:_____**	**200mg**	☐ **≤ 75 kg: take 600 mg by mouth every morning and 400 mg every evening (total dose 1000 mg daily)** ☐ **≥75 kg: take 600 mg by mouth every morning and 600 mg every evening (total dose 1200 mg daily)** ☐ **Other:**		
☐ **Xifaxan (hepatic encephalopathy)**	**550 mg tablet**	**Take one tablet by mouth twice daily**		
☐ **Other:**				

☐ Ship first order to the office for nurse visit/teach ☐ Ship order to patient, complete phone education ☐ Ship all orders to office

☐ Dispense as written → generic will be dispensed unless this box checked (Harvoni and Epclusa generic available January 2019)

SIGNATURE:		DATE:	
PHYSICIAN NAME:	DEA #:	NPI #:	STATE LICENSE #:
PRACTICE NAME:	ADDRESS:	CITY, STATE:	ZIP:
PHONE #:	FAX:	OFFICE CONTACT:	

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients. Following prior authorization, if insurance dictates the prescription be filled at a specific pharmacy ABD will forward the prescription to that pharmacy and the office and patient will be notified