



HEPATITIS C VIRUS SPECIALTY CARE PROGRAM

Phone: **888-216-1949** • Fax: **888-977-1391**



1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: M F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Diagnostic Information

Date of Diagnosis: _____ ICD-10: _____ Other: _____
Genotype: _____ Subtype: _____ Q80K: Positive Negative (For Genotype 1a)
Indicate Patient Status: Naïve Partial Responder Non-responder Null-responder Relapser
Duration of Previous Therapy: _____ Weeks From: _____ To: _____
Cirrhosis: No Yes If Yes: Compensated Decompensated
History of Liver Biopsy? No Yes If Yes, Please Attach Results
 Fibrosure or Fibroscan: Results: _____
Extra-Hepatic Manifestations: Ascites Hepatic Encephalopathy Thrombocytopenia
 Other: _____
Does the patient need liver transplantation? Yes No

Labs

ALT: _____ HGB: _____
AST: _____ HCV RNA: _____
PLT: _____ SrCr: _____
Date: _____

Medication List and Contraindications

Attach Medication List
Is the patient interferon ineligible? No Yes
 Anxiety Depression Pulmonary Abnormalities
 Renal Insufficiency Other: _____

If Prior Authorization is Denied:

Automatically Draft Appeal for Review Send Formulary Preferred Alternatives

4 PRESCRIPTION INFORMATION: Duration of Therapy: 8 Weeks 12 Weeks 24 Weeks Other _____

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> DAKLINZA™	<input type="checkbox"/> 30mg Tablets <input type="checkbox"/> 60mg Tablets	<input type="checkbox"/> Take 30mg daily with or without food <input type="checkbox"/> Take 60mg daily with or without food <input type="checkbox"/> Take 90mg daily with or without food	28 28 84	
<input type="checkbox"/> HARVONI®	<input type="checkbox"/> 90mg/400mg Tablet	Take one tablet daily with or without food	28	
<input type="checkbox"/> OLYSIO™	<input type="checkbox"/> 150mg Capsules	Take one 150mg capsule orally once a day	28	
<input type="checkbox"/> SOVALDI®	<input type="checkbox"/> 400mg Tablets	Take one 400mg tablet orally once a day	28	
<input type="checkbox"/> VIEKIRA PAK™	<input type="checkbox"/> 12.5/75/50mg & 250mg Dose Pack	Take three tablets in the morning and one tablet in the evening with a meal, as directed on the daily dose pack	1 Pack	
<input type="checkbox"/> MODERIBA Dose Pack™ <input type="checkbox"/> RIBASPHERE RibaPack®	<input type="checkbox"/> 600mg per day <input type="checkbox"/> 800mg per day <input type="checkbox"/> 1000mg per day <input type="checkbox"/> 1200mg per day	<input type="checkbox"/> Take 200mg tablet every morning/400mg tablet every evening <input type="checkbox"/> Take 400mg tablet every morning/400mg tablet every evening <input type="checkbox"/> Take 600mg tablet every morning/400mg tablet every evening <input type="checkbox"/> Take 600mg tablet every morning/600mg tablet every evening		
<input type="checkbox"/> MODERIBA™ <input type="checkbox"/> RIBASPHERE® <input type="checkbox"/> RIBAVIRIN	<input type="checkbox"/> 200mg Tablets <input type="checkbox"/> 200mg Capsules	Take _____ tablets/capsules every morning and, Take _____ tablets/capsules every evening		
<input type="checkbox"/> TECHNIVIE™	<input type="checkbox"/> 12.5/75/50mg Tablets	Take two tablets once daily in the morning with a meal	56	
<input type="checkbox"/> XIFAXAN®	<input type="checkbox"/> 550mg Tablets	Take one tablet twice daily with or without food	60	
<input type="checkbox"/> _____	_____	_____		

5 INJECTION TRAINING: To Be Administered by Pharmacist Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

6 PICK UP OR DELIVERY: Delivery to Patient's Home Delivery to Physician's Office Pharmacy to Coordinate

7 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

8 PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____
Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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