WHOLE HEALTH PHARMACY

Hepatitis C Enrollment Form

Fax: 949-340-8008
Phone: 949-305-0788
□ **Urgent Request**
Rep: _____

PATIENT INFORMATION

*Please complete the following or **send patient demographic sheet***
Patient Name _____
Address _____
Address 2 _____
City, State, Zip _____
Home Phone _____ Mobile Phone _____
DOB _____Last Four of SS _____ Gender _____
Language Preference _____

PRESCRIBER INFORMATION

Prescriber Name _____
DEA _____
NPI _____
Address _____
City, State, Zip _____
Phone _____ Fax _____
Contact Person _____

Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests, and previous medical history to expedite prior authorization

Diagnosis - Please include diagnosis name with ICD-10 code | Additional information | □ New Therapy □ Reauthorization

□ B18.2 Chronic Hepatitis C □ K72.90 Hepatic failure, unspecified without coma (Hepatic encephalopathy) □ C22.0 Liver Cell Carcinoma (HCC)
□ Other Diagnosis: ICD-10 Code _____
Description _____
Genotype _____ Viral Load _____IU/ml Viral Load Date _____ HIV Coinfected □ Yes □ No HBV Coinfected □ Yes □ No
Previous therapy history: Naïve _____ Relapsed _____ Partial Responder _____ Null _____
Date(s) of previous therapy and meds _____
Cirrhosis: □ Yes □ No □ Compensated OR □ Decompensated □ Fibrosis Score _____ □ Child-Pugh Score _____
Liver Transplant: □ Yes □ No Waiting for Liver Transplant: □ Yes □ No
Please include hard copies of genotype, viral load, Metavir Score, CBC, CMP, HIV, PT/INR, NS5a resistance testing, and chart notes

PRESCRIPTION INFORMATION

Medication/Strength	Recommended Dosing Guidelines	Directions	Quantity	Refills
□ Epclusa (sofosbuvir 400mg/velpatasvir 100mg)	Genotype **1-6** without cirrhosis or compensated cirrhosis **12 weeks** Genotype **1-6** decompensated cirrhosis + Ribavirin 12 **weeks**	1 PO QD	□ # 28	
□ Harvoni (ledipasiv 90mg/sofosbuvir 400mg)	Genotype **1** Treatment naïve, non-cirrhotic HCV RNA < 6 million IU; **8 weeks** Genotype **1** Treatment naïve without cirrhosis or with compensated cirrhosis; **12 weeks** Genotype **1** Treatment experienced with compensated cirrhosis; **24 weeks** Genotype **1** Treatment naïve and treatment experienced decompensated cirrhosis; **12 weeks with Ribavirin** Genotype **1 or 4** Treatment naïve and treatment experienced liver transplant recipients without cirrhosis or with compensated cirrhosis **12 weeks with Ribavirin** Genotype **4, 5, or 6** Treatment naïve and treatment experienced, without cirrhosis or with compensated cirrhosis **12 weeks**	1 PO QD	□ # 28	
□ Mavyret (glecaprevir 100mg/pibrentasivir 40mg)	Genotype **1, 2, 3, 4, 5, or 6** Treatment Naïve with no cirrhosis **8 weeks** Genotype **1,2,3,4,5, or 6** Treatment Naïve with compensated cirrhosis 12 weeks Genotype **1** treatment experienced with NS5A with no cirrhosis or compensated cirrhosis **16 weeks** Genotype **1** treatment experienced with NS3/4 with no cirrhosis or compensated cirrhosis **12 weeks** Genotype **1, 2, 3, 4, 5, or 6** Treatment experienced PRS with no cirrhosis **8 weeks** Genotype **1, 2, 3, 4, 5, or 6** Treatment experienced PRS with cirrhosis **12 weeks**	3 PO QD	# 84	
Ribavirin 200mg tablets			# 28 days	
Sovaldi (sofosbuvir 400mg tablets)		1 PO QD	# 28	
Vosevi (400mg sofosbuvir,100mg velpatasiv, and 100mg Voxilaprevir)	Genotype **1,2,3,4,5, or 6** – Patients previously treated with NS5A **12 weeks** Genotype **1a or 3** – Patients previously treated with HCV regimen containing sofosbuvir without NS5A **12 weeks**	1 PO QD	# 28	
Zepatier (elbasvir 50mg and grazoprevir 100mg)	Genotype **1a**, without baseline polymorphism :**12 weeks** Genotype **1a**, with NS5A polymorphisms + Ribavirin:**16 weeks** Genotype **1b**: **12 weeks** Genotype **1a** or **1b** Interferon experienced + Ribavirin **12 weeks** Genotype **4** Treatment naïve: **12 weeks** Genotype **4** Treatment experienced + Ribavirin **16 weeks**	1 PO QD	# 28	
Other				

Ship to: □ Patient □ Office □ Other _____ Date: _____ Need by Date _____

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s) and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorizations forms and the receipt and submission of patient tab values and other patient data, in the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize the pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.
□ Product Substitution permitted □ Dispense as Written

Prescriber's Signature: _____Date: _____