

Hepatitis C Virus

Patient Information		Prescriber + Shipping Information		
Patient name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____ Ethnicity: _____ Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate: _____ Caregiver name: _____ Relation: _____ Local pharmacy: _____ Phone: _____ Insurance plan: _____ Plan ID: _____ Please fax a copy of front and back of the insurance card(s).		Prescriber name: _____ NPI: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email: _____ If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never		
Clinical Information (Please fax pertinent clinical and lab information)				
Diagnosis: <input type="checkbox"/> B18.2 (Chronic Hepatitis C Virus) Diagnosis date: _____ Genotype: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 Subtype: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> A/B <input type="checkbox"/> N/A Baseline viral load: _____ Date: _____ Degree of fibrosis: <input type="checkbox"/> F0 <input type="checkbox"/> F1 <input type="checkbox"/> F2 <input type="checkbox"/> F3 <input type="checkbox"/> F4 <input type="checkbox"/> _____ Cirrhosis: <input type="checkbox"/> None <input type="checkbox"/> Compensated <input type="checkbox"/> Decompensated (CTP: <input type="checkbox"/> B <input type="checkbox"/> C) Co-infection(s): <input type="checkbox"/> None <input type="checkbox"/> HIV <input type="checkbox"/> HBV		Transplant status: <input type="checkbox"/> N/A <input type="checkbox"/> Pre-transplant <input type="checkbox"/> Post-transplant sCr: _____ GFR: _____ Date: _____ CKD stage: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> N/A Dialysis: <input type="checkbox"/> Yes <input type="checkbox"/> No IL28B polymorphism: <input type="checkbox"/> CC <input type="checkbox"/> CT <input type="checkbox"/> TT Q80K polymorphism: <input type="checkbox"/> Yes <input type="checkbox"/> No NS5A polymorphism: <input type="checkbox"/> Yes <input type="checkbox"/> No NS5A polymorphism type: <input type="checkbox"/> M28 <input type="checkbox"/> Q30 <input type="checkbox"/> L31 <input type="checkbox"/> Y93 <input type="checkbox"/> _____		
Prior Regimen <input type="checkbox"/> Naïve <input type="checkbox"/> Experienced (List below) _____ _____ _____	Start Date _____ _____ _____	End Date _____ _____ _____	Treatment Weeks _____ _____ _____	Response* <input type="checkbox"/> IC <input type="checkbox"/> NR <input type="checkbox"/> PR <input type="checkbox"/> RLP <input type="checkbox"/> IC <input type="checkbox"/> NR <input type="checkbox"/> PR <input type="checkbox"/> RLP <input type="checkbox"/> IC <input type="checkbox"/> NR <input type="checkbox"/> PR <input type="checkbox"/> RLP
<i>*Response definitions: IC – Incomplete treatment, NR – Null Responder, PR – Partial Response, RLP – Relapser</i>				
Comorbidities: _____ Concomitant Medications: _____ Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____				
Prescription	Quantity	Duration	Refill	
<input type="checkbox"/> Daklinza® (daclatasvir)	<input type="checkbox"/> Take 30 mg by mouth once daily <input type="checkbox"/> Take 60 mg by mouth once daily <input type="checkbox"/> Take 90 mg by mouth once daily	<input type="checkbox"/> 28 x 30 mg tablets <input type="checkbox"/> 28 x 60 mg tablets <input type="checkbox"/> 28 x 90 mg tablets	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks _____	
<input type="checkbox"/> Epclusa® (velpatasvir/sofosbuvir)	<input type="checkbox"/> Take 100 mg/400 mg by mouth once daily	<input type="checkbox"/> 28 x 100 mg/400 mg tablets	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks _____	
<input type="checkbox"/> Harvoni® (ledipasvir/sofosbuvir)	<input type="checkbox"/> Take 90 mg/400 mg by mouth once daily	<input type="checkbox"/> 28 x 90 mg/400 mg tablets	<input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks _____	
<input type="checkbox"/> Olysio® (simeprevir)	<input type="checkbox"/> Take 150 mg by mouth once daily	<input type="checkbox"/> 28 x 150 mg capsules	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks _____	
<input type="checkbox"/> Sovaldi® (sofosbuvir)	<input type="checkbox"/> Take 400 mg by mouth once daily	<input type="checkbox"/> 28 x 400 mg tablets	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks _____	
<input type="checkbox"/> Technivie™ (ombitasvir/paritaprevir/ritonavir)	<input type="checkbox"/> Take 2 tablets by mouth in the morning with food	<input type="checkbox"/> 56 x 12.5 mg/75 mg/50 mg tablets	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks _____	
<input type="checkbox"/> Viekira Pak® (dasabuvir/ombitasvir/paritaprevir/ritonavir)	<input type="checkbox"/> Take 3 tablets by mouth in the morning and 1 tablet by mouth in the evening with food	<input type="checkbox"/> 112 x 250 mg/12.5 mg/75 mg/50 mg tablets	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks _____	
<input type="checkbox"/> Viekira XR™ (dasabuvir/ombitasvir/paritaprevir/ritonavir)	<input type="checkbox"/> Take 3 tablets by mouth once daily with food	<input type="checkbox"/> 84 x 200 mg/8.33 mg/50 mg/33.33 mg tablets	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks _____	
<input type="checkbox"/> Zepatier™ (elbasvir/grazoprevir)	<input type="checkbox"/> Take 50 mg/100 mg by mouth once daily	<input type="checkbox"/> 28 x 50/100 mg tablets	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 16 weeks _____	
<input type="checkbox"/> Pegasys® (peginterferon alfa-2a)	<input type="checkbox"/> Inject 180 mcg subcut once weekly <input type="checkbox"/> _____	<input type="checkbox"/> 4 x 180 mcg	<input type="checkbox"/> PFS <input type="checkbox"/> Autoinjector _____	
<input type="checkbox"/> Ribasphere® Ribapak® Dose Pak (ribavirin) <input type="checkbox"/> Moderiba™ Dose Pack (ribavirin)	<input type="checkbox"/> Take _____ mg tablet by mouth every morning, _____ mg tablet by mouth every evening (_____ mg/day)	<input type="checkbox"/> 28 x 200 mg; 28 x 400 mg <input type="checkbox"/> 28 x 400 mg; 28 x 400 mg <input type="checkbox"/> 28 x 400 mg; 28 x 600 mg <input type="checkbox"/> 28 x 600 mg; 28 x 600 mg	Tablets _____	
<input type="checkbox"/> Ribasphere®** (ribavirin)	<input type="checkbox"/> Take _____ mg tablet by mouth every morning, _____ mg tablet by mouth every evening (_____ mg/day)	<input type="checkbox"/> _____ x 200 mg	<input type="checkbox"/> Tablets <input type="checkbox"/> Capsules _____	
**For the form (tablets or capsules), unless otherwise specified, pharmacy preference/availability (or insurance preference) will be dispensed.				
Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____				
Prescriber's Signature: _____ Date: _____				

I authorize Wellgistics Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization and appeal process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Wellgistics Pharmacy.

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