Hepatitis C (HCV) Enrollment Form

Phone: (706) 849-4161 **Fax:** (706) 798-9683

PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name:_____ DOB:_____
Address: _____
City, State, Zip:_____
Primary Phone:_____
Alternate Phone:_____ Gender:_____
Email:_____
SSN:_____
Allergies:_____

PRESCRIBER INFORMATION

Prescriber Name: _____
State License #: _____ NPI#: _____
DEA#: _____
Organization:_____
Address:_____
City, State, Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Tax ID: _____

INSURANCE INFORMATION: Please fax/scan the front and back of the insurance card

DIAGNOSIS AND CLINICAL INFORMATION *(Prescriber must provide the following)*

Ship to: ☐ Patient ☐ Office ☐ Other (specify): _____ Diagnosis Date:_____ Starting RNA Titer:_____
Diagnosis (ICD-10 code): _____

Patient Evaluation: HCV Genotype: ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 Height (cm):_____ Weight (kg):_____

Autoimmune hepatitis or another condition known to be exacerbated by interferon or ribavirin? ☐ Yes ☐ No

Status: ☐ Naïve ☐ Partial resp. ☐ Null-resp. ☐ Non-resp. ☐ Relapse Last date of therapy: _____ Product Names: _____

Is patient currently on (HCV) therapy? ☐ Yes ☐ No If Yes, Therapy start date: _____ Product names: _____

Requested start date for (HCV) therapy: _____ ☐ Attached active medication list for pharmacist review

Has patient previously failed therapy with a treatment regimen that included a protease inhibitor? ☐ Yes ☐ No HIV co-infected ☐ Yes ☐ No

Patient Education: Expected date: _____ ☐ MD office ☐ Barney's Specialty ☐ Alternate program

Prescription Information

HARVONI® (ledipasvir/sofosbuvir)
Directions: Take one tablet (90mg-400mg) PO daily
Quantity: _____ Refills: _____

RIBAVIRIN ☐ 200mg capsules ☐ 200mg tablets
Directions: Take ____ tabs/caps PO QAM and ____ tabs/caps PO QPM
Quantity: _____ Refills:_____

VIEKIRA PAK® (ombitasvir/paritaprevir/ritonavir/dasabuvir)
Directions: Take two tablets (12.5mg/75mg/50mg) once daily (in the morning) and take one tablet (250 mg) twice daily (morning and evening) with a meal
Quantity:_____ Refills: _____

DAKLINZA® (daclatasvir) ☐ 30mg ☐ 60mg
Directions: Take one tablet PO daily with Sovaldi®
Quantity: _____Refills: _____

SOVALDI® (sofosbuvir)
Directions: Take 1 tablet (400mg) PO daily
Quantity: _____ Refills: _____

TECHNIVIE® (ombitasvir/paritaprevir/ritonavir)
Directions: Take two tablets PO daily in the morning
Quantity:_____Refills:_____

ZEPATIER® (elbasvir/grazoprevir)
Directions: Take 1 tablet (50/100) PO daily
Quantity: _____ Refills: _____

EPCLUSA® (sofosbuvir/velpatazvir)
Directions: Take one tablet (400mg/100mg) PO daily
Quantity: _____ Refills: _____

Patient Support Program: Please sign and date below to enroll in the pharmaceutical company assisted patient support programs and patient funding.

PATIENT SIGNATURE:_____ Date: _____

****By signing this form and utilizing our services, you are authorizing Barney's Specialty Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.****

X_____ _____ X_____ _____
Dispense as written Date Substitution Permitted Date