

Patient Information

Date Medication Needed: ____/____/____ Deliver to: Patient's Home Prescriber's Office

Patient's Name: _____ DOB: ____/____/____ Height: _____ Weight: _____
 Gender: _____ SSN: _____ - _____ - _____ Home Phone: _____ Cell Phone: _____
 Address: _____ City: _____ State: _____ ZIP: _____
 Emergency Contact: _____ Relation: _____ Phone: _____
 Allergies: _____

Insurance Information

Primary Insurer: _____ Phone: _____ Person Code: _____
 Policy #: _____ Group #: _____ Rx BIN: _____ Rx PCN: _____
 Secondary Insurer: _____ Phone: _____ Person Code: _____
 Policy #: _____ Group #: _____ Rx BIN: _____ Rx PCN: _____

Prescriber Information

Prescriber's Name: _____ Practice: _____
 Address: _____ City: _____ State: _____ ZIP: _____
 Contact Name: _____ Phone: _____ Fax: _____
 DEA: _____ NPI: _____

Clinical Information

Diagnosis: _____ ICD-10 Code: _____
 Genotype: _____ HCV-RNA (IU/mL): _____
 Patient is: Naïve Non-Responder Partial Responder Relapser Transplant Fibrosis Score: _____ Compensated Cirrhosis: Yes No
 Previously Treated: Medications: _____ Length of Treatment: _____

Prescription Information

Medication	Dose/Strength	Signature	Qty	Refills
<input type="radio"/> Zepatier™ (elbasvir, grazoprevir)	<input type="radio"/> 50mg/100mg tablets	<input type="radio"/> 1 tablet (50mg/100mg) PO daily with or without food	1 Month	
<input type="radio"/> Epclusa® (sofosbuvir, velpatasvir)	<input type="radio"/> 400mg/100mg tablets	<input type="radio"/> 1 tablet PO daily with or without food	1 Month	
<input type="radio"/> Harvoni® (ledipasvir, sofosbuvir)	<input type="radio"/> 90mg/400mg tablets	<input type="radio"/> 1 tablet (90mg/400mg) PO daily with or without food	1 Month	
<input type="radio"/> Daklinza® (daclatasvir)	<input type="radio"/> 30mg tablets <input type="radio"/> 60mg tablets	<input type="radio"/> 30mg once daily <input type="radio"/> 60mg once daily <input type="radio"/> 90mg once daily (30mg tablet + 60mg tablet)	1 Month	
<input type="radio"/> Olysio® (simeprevir)	<input type="radio"/> 150mg tablets	<input type="radio"/> 1 tablet (150mg) PO daily with food <input type="radio"/> Other: _____	1 Month	
<input type="radio"/> Ribavirin®	<input type="radio"/> 200mg tablets		1 Month	
<input type="radio"/> Sovaldi® (sofosbuvir)	<input type="radio"/> 400mg tablets	<input type="radio"/> 1 tablet (400mg) PO daily with or without food <input type="radio"/> Other: _____	1 Month	
<input type="radio"/> Viekira XR™ (dasabuvir, ombitasvir, paritaprevir and ritonavir)	<input type="radio"/> 200mg/8.33mg/50mg/33.33mg tablets	<input type="radio"/> Take 3 tablets PO once daily with food	1 Month	
<input type="radio"/> Technivie® (ombitasvir, paritaprevir, ritonavir)	<input type="radio"/> 12.5mg/75mg/50mg	<input type="radio"/> Take one dose pack daily as directed	1 Month	
<input type="radio"/> Other:			1 Month	

I certify that I am prescribing the drug(s) listed above. I authorize Pharmacy to perform the above services on behalf of Physician for the benefit of the patient.

Prescriber's Signature: _____ Date: ____/____/____