paramount specialty pharmacy

Hepatitis C Enrollment

P: 855.821.6300 • F: 866.266.6319
paramountsprx.com

To E-Prescribe: NABP: 3324427

Patient Information

Date Medication Needed: _____ /______ /______ Deliver to: ◯ Patient's Home ◯ Prescriber's Of ce

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
◯ **Zepatier™** (elbasvir, grazoprevir)	◯ 50mg/100mg tablets	◯ 1 tablet (50mg/100mg) PO daily with or without food	1 Month	
◯ **Epclusa®** (sofosbuvir, velpatasvir)	◯ 400mg/100mg tablets	◯ 1 tablet PO daily with or without food	1 Month	
◯ **Harvoni®** (ledipasvir, sofosbuvir)	◯ 90mg/400mg tablets	◯ 1 tablet (90mg/400mg) PO daily with or without food	1 Month	
◯ **Mavyret®** (glecaprevir/pibrentasvir)	◯ 100mg/40mg tablets	◯ 3 Tablets PO daily with food	1 Month	
◯ **Vosevi®** (sofosbuvir/velpatasvir/voxilaprevir)	◯ 400mg/100mg/100mg	◯ 1 tablet PO daily with food	1 Month	
◯ **Ribavirin®**	◯ 200mg tablets		1 Month	
◯ **Viekira XR™** (dasabuvir, ombitasvir, paritaprevir and ritonavir)	◯ 200mg/8.33mg/50mg/33.33mg tablets	◯ Take 3 tablets PO once daily with food	1 Month	
◯ 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: ______ /______ /______

IMPORTANT NOTICE: This fax is intended to be delivered to the named addressee only and contains con dential information that may be protected health information under federal and state laws. If you are not the intended recipient, please notify the sender immediately and destroy this document.