

HEPATOLOGY ENROLLMENT FORM

PATIENT INFORMATION

Name (First, Last): _____ ☐ Male ☐ Female
Address: _____ **City:** _____ **State:** ____ **Zip Code:** ____
Phone: (____) ____ - ____ **Date of Birth (mm/dd/yyyy) :** ____ / ____ / ____ **Social Security #** ____ - ____ - ____

PLEASE FAX COPY OF INSURANCE CARD (Front & Back)

Medication	Dose/Strength	Directions	Quantity	Refills
<input type="checkbox"/> DAKLINZA	<input type="checkbox"/> 30mg <input type="checkbox"/> 60mg <input type="checkbox"/> 90mg	Take 1 tablet PO QD for 28 days	28	
<input type="checkbox"/> EPCLUSA	<input type="checkbox"/> 400mg/100MG	Take 1 tablet PO QD for 28 days	28	
<input type="checkbox"/> HARVONI	<input type="checkbox"/> 90mg/400mg	Take 1 tablet PO QD for 28 days	28	
<input type="checkbox"/> MAVYRET	<input type="checkbox"/> 100mg/40mg	Take 3 tablets PO With Food QD for 28 days	84	
<input type="checkbox"/> RIBAPAK	<input type="checkbox"/> 400mg/400mg <input type="checkbox"/> 600mg/400mg <input type="checkbox"/> 600mg/600mg	<input type="checkbox"/> 400mg A.M & 400mg P.M <input type="checkbox"/> 600mg A.M & 400mg P.M <input type="checkbox"/> 600mg A.M & 400mg P.M	28	
<input type="checkbox"/> VIEKIRA PAK	<input type="checkbox"/> 250mg/12.mg/75mg/50mg	Take 3 tablets by mouth in the morning and 1 tablet by mouth in the evening with food	112	
<input type="checkbox"/> ZEPATIER	<input type="checkbox"/> 50mg/100mg	Take 50 mg/100 mg by mouth once daily	28	
<input type="checkbox"/> VIREAD	<input type="checkbox"/> 300mg	Take 1 tablet PO QD	30	
<input type="checkbox"/> VEMLIDY	<input type="checkbox"/> 25mg	Take 1 tablet PO QD	30	
<input type="checkbox"/> OTHER				

DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis: ☐ B18.2 (Chronic Hepatitis C Virus) ☐ Other

Diagnosis date: _____

Genotype: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

Baseline viral load: _____

Degree of fibrosis: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4 ☐

Cirrhosis: ☐ None ☐ Compensated ☐ Decompensated

Co-infection(s): ☐ None ☐ HIV ☐ HBV

Transplant status: ☐ N/A ☐ Pre-transplant ☐ Post-transplant Date: _____

Prior Regimen ☐ Naïve ☐ Experienced (List below)

Previous Treatment _____

If Yes, was patient a ☐ Non-Responder ☐ Responder ☐ Relapsed

IL28B polymorphism: ☐ CC ☐ CT ☐ TT

Other Comorbidities _____

Allergies _____

Total # of Dangerous Drugs Prescribed _____

PRESCRIBER'S INFORMATION

Prescriber Name (First, Last): _____ **NPI #:** _____

Address: _____ **DEA #:** _____

City: _____ **State:** ____ **Zip Code:** ____

Phone: (____) ____ - ____ **Fax:** (____) ____ - ____ **Contact Name:** _____

Physician Signature: _____ **Date:** ____ / ____ / ____

I authorize 986 Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process

IMPORTANT NOTICE: This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.

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