986 PHARMACY SPECIALTY

FAX: 626-798-8376
1719 E. Walnut St.
Pasadena, CA 91106
Tel: 626-798-6789

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
☐ **DAKLINZA**	☐ **30mg** ☐ **60mg** ☐ **90mg**	Take 1 tablet PO QD for 28 days	28	
☐ **EPCLUSA**	☐ **400mg/100MG**	Take 1 tablet PO QD for 28 days	28	
☐ **HARVONI**	☐ **90mg/400mg**	Take 1 tablet PO QD for 28 days	28	
☐ **MAVYRET**	☐ **100mg/40mg**	Take 3 tablets PO With Food QD for 28 days	84	
☐ **RIBAPAK**	☐ **400mg/400mg** ☐ **600mg/400mg** ☐ **600mg/600mg**	☐ 400mg A.M & 400mg P.M ☐ 600mg A.M & 400mg P.M ☐ 600mg A.M & 400mg P.M	28	
☐ **VIEKIRA PAK**	☐ **250mg/12.mg/75mg/50mg**	Take 3 tablets by mouth in the morning and 1 tablet by mouth in the evening with food	112	
☐ **ZEPATIER**	☐ **50mg/100mg**	Take 50 mg/100 mg by mouth once daily	28	
☐ **VIREAD**	☐ **300mg**	Take 1 tablet PO QD	30	
☐ **VEMLIDY**	☐ **25mg**	Take 1 tablet PO QD	30	
☐ **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