Hepatitis - C Enrollment Form

Phone: 800-476-7496
Fax: 888-985-9223

SINCE 1933 BOOTHWYN PHARMACY

PATIENT INFORMATION					
Patient Name				☐ Male ☐ Female	
Date of Birth	SS#	Phone (Home)		(Work)	
Address		City	State		Zip

PHARMACY INSURANCE INFORMATION (PLEASE ATTACH COPY OF PATIENT CARD – FRONT AND BACK)		
Primary Insurance		Policy Holder
Policy #	Group #	Phone

CLINICAL DIAGNOSIS / MEDICAL INFORMATION (Indicate primary and secondary diagnosis – include lab reports and clinical notes)

☐ 070.54 Hepatitis – C (Chronic) ☐ Other ICD9 _____ Initial Viral Load - HCV RNA: _____ IU/mL Date: _____

Genotype: ☐ 1 ☐ 1a* ☐ 1b ☐ 2 ☐ 2a ☐ 2b ☐ 3 ☐ 3a ☐ 3b ☐ 4 ☐ 4 ☐ 4a ☐ 4b ☐ 5 ☐ 6 ☐ Other
*1a - Is the Q80K polymorphism present? ☐ Yes ☐ No

Date of Diagnosis: _____ ☐ Treatment Naive ☐ Previous Treatment _____ ☐ Non-Responder ☐ Partial-Responder ☐ Relapser
Duration of Prior Treatment from: _____ to: _____ Total weeks: _____

HIV Co-Infected ☐ Yes ☐ No HBV Co-Infected ☐ Yes ☐ No Cirrhosis ☐ Yes ☐ No if, Yes: ☐ Compensated ☐ Decompensated
Concomitant medications: _____ Other Health Conditions: _____

Liver Biopsy ☐ Yes ☐ No Yes; Metavir Score ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4 Transplant recipient ☐ Yes ☐ No Awaiting transplant ☐ Yes ☐ No

Patient Weight: _____ kg. OR _____ lbs. Drug Allergies: _____ or ☐ NKDA

PRESCRIPTION INFORMATION

Rx-Medication	*Dose*	*Instructions and Frequency*	*Quantity*	*Refills*
☐ **Viekira Pak™** (ombitasvir, paritaprevir, and ritonavir tablets; dasabuvir tablets), co-packaged for oral use	☐Pak contains: ombitasvir, paritaprevir, ritonavir (pink tablets): 12.5/75/50 mg dasabuvir (beige tablets): 250 mg	☐ Take two ombitasvir, paritaprevir, ritonavir (pink) tablets once dailyAM and one dasabuvir (beige) tablet twice daily AM and PM with a meal ☐ Other _____ Duration: ☐ 12 weeks ☐ 24 weeks	☐ 28 Day Supply	
☐ **Harvoni™** (ledipasvir/sofosbuvir)	☐90 mg/400 mg tablets	Take 1 tablet by mouth daily	☐ 28 Day Supply	
☐ **Sovaldi™** (sofosbuvir)	☐400 mg tablets	Take 1 tablet by mouth daily	☐ 28 Day Supply	
☐ **Olysio™** (simeprevir)	☐150 mg capsules	Take 1 capsule by mouth daily	☐ 28 Day Supply	
☐ **Pegasys®** (peginterferon alpha2a) ☐ Prefilled Syringe ☐ Vial ☐ ProClick	☐ 180 mcg ☐ 135 mcg	☐ 180 mcg SQ once weekly ☐ 90 mcg SQ once weekly ☐ 135 mcg SQ once weekly	☐ 28 Day Supply	
☐ **PegIntron®** (peginterferon alpha2b) ☐ Redipen	☐ 50 mcg/0.5ml ☐ 80 mcg/0.5ml ☐ 120 mcg/0.5ml ☐ 150 mcg/0.5ml	☐ 50 mcg (0.5ml) SQ once weekly ☐ 64 mcg (0.4ml) SQ once weekly ☐ 80 mcg (0.5ml) SQ once weekly ☐ 96 mcg (0.4ml) SQ once weekly ☐ 120 mcg (0.5ml) SQ once weekly ☐ 150 mcg (0.5ml) SQ once weekly	☐ 28 Day Supply	
☐ **Moderiba®** (ribavirin) or ☐ **RibaPak®** (ribavirin)	☐ Dose Pack	☐ 600-600: 600mgAM/600mgPM=1,200mg/day ☐ 600-400: 600mgAM/400mgPM=1,000mg/day ☐ 400-400: 400mgAM/400mgPM=800mg/day ☐ 200-400: 200mgAM/400mgPM=600mg/day	☐ 28 Day Supply	
☐ Ribavirin - Generic	☐ 200 mg tablet	☐ _____	☐ 28 Day Supply	

DELIVERY AND PATIENT EDUCATION INSTRUCTIONS

☐ Patient's Home ☐ Physician's Office Date Needed: Patient needs Education Kit? ☐ yes ☐ no

PHYSICIAN CONTACT INFORMATION AND AUTHORIZATION			
Physician Name	License #	DEA #	UPIN #
Office Contact	Phone	Fax	NPI#
Address	City/State/Zip		
Physician's Signature	Date (required)		

This prescription will be filled generically unless prescriber writes "DAW" in the box to the right. ☐