



Hepatitis C

Patient Information:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Alt Phone: _____
 Email: _____
 DOB: _____ Height: _____ Weight: _____
 Gender: M F Caregiver: _____

Prescriber Information:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 NPI: _____ DEA: _____
 Tax ID: _____
 Office Contact: _____ Phone: _____

CLINICAL INFORMATION: Diagnosis: B18.2 Chronic Hepatitis C B17.10 Acute Hepatitis C
 Z94.4 Liver Transplant B20 HIV B16. Acute Hepatitis B Other (ICD-10 Code): _____

Drug Allergies: _____

Genotype: 1a (NS5A RAVs) 1b 2 3 4 5 6

Responder Status: Naïve Relapsed Partial Responder Non-Responder

Fibrosis Stage: F0 F1 F2 F3 F4 **Viral Load:** _____ **Load Date:** _____

Cirrhosis Decompensated Liver Transplant Candidate Solid Organ Transplant Recipient

Prior Therapy (include dates): _____

PLEASE FAX COPIES: Medical Card (Front and Back) Prescription Card (Front and Back) Clinical Notes

Medication	Dosage and Strength	Directions	Quantity	Refills
<input type="checkbox"/> Daklinza™ (daclatasvir)	<input type="checkbox"/> 30mg tablet <input type="checkbox"/> 60mg tablet <input type="checkbox"/> 90mg tablet	Take 1 tablet PO daily with or without food <i>Administer with sofosbuvir</i>	#28	
<input type="checkbox"/> Epclusa®	400mg/100mg tablet (sofosbuvir/velpatasvir)	Take 1 tablet PO daily with or without food	#28	
<input type="checkbox"/> Harvoni®	90mg/400mg tablet (ledipasvir/sofosbuvir)	Take 1 tablet PO daily with or without food	#28	
<input type="checkbox"/> Mavyret™	100mg/40mg tablet (glecaprevir/pibrentasvir)	Take 3 tablets PO daily with food	4 weeks	
<input type="checkbox"/> Sovaldi® (sofosbuvir)	400mg tablet	Take 1 tablet PO daily with or without food	#28	
<input type="checkbox"/> Viekira Pak™	12.5mg/75mg/50mg tablet (ombitasvir/paritaprevir/ritonavir+dasabuvir 250mg tablet)	Take 2 tablets PO every morning and 1 tablet (dasabuvir) twice daily (every morning and every evening) with a meal as directed in the Pak	4 weeks	
<input type="checkbox"/> Vosevi™	400mg/100mg/100mg tablet (sofosbuvir/velpatasvir/voxilaprevir)	Take 1 tablet PO daily with food	#28	
<input type="checkbox"/> Zepatier™	50mg/100mg (elbasvir/grazoprevir)	Take 1 tablet PO daily with or without food	#28	
<input type="checkbox"/> Ribavirin	<input type="checkbox"/> 200mg tablets <input type="checkbox"/> 200mg capsules <input type="checkbox"/> 200mg Moderiba <input type="checkbox"/> Moderiba Dose Pack	<input type="checkbox"/> 1400mg - 600mg PO every morning and 800mg PO every evening <input type="checkbox"/> 1200mg - 600mg PO every morning and 600mg PO every evening <input type="checkbox"/> 1000mg - 400mg PO every morning and 600mg PO every evening <input type="checkbox"/> 800mg - 400mg PO every morning and 400mg PO every evening <input type="checkbox"/> Other: _____ - _____ PO every morning and _____ PO every evening	4 weeks	
<input type="checkbox"/> Riba-Pak®	<input type="checkbox"/> 200mg/400mg <input type="checkbox"/> 600mg/400mg <input type="checkbox"/> 400mg/400mg <input type="checkbox"/> 600mg/600mg	Take 1 tablet PO every morning and 1 tablet PO every evening	4 weeks	
<input type="checkbox"/> Other:				

By signing this form and utilizing our services, you are authorizing FountainRx or its designee to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and patient assistance programs. My signature certifies that the person named on this form is my patient, the information provided on this application, to the best of my knowledge, is complete and accurate and the therapy identified is medically necessary.

Physician Signature: _____ **Date:** _____