2825 W. A.J. Hwy. Morristown, TN 37814
Phone: 423-307-5757
6900 Lenox Village Dr., Ste #14 Nashville, TN 37211
Phone: 615-864-8990

FountainRx

Hepatitis C

Please fax patient demographics with prescription order form to:

Toll-Free 1-844-621-5199

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
☐ **Epclusa®**	400mg/100mg tablet (sofosbuvir/velpatasvir)	Take 1 tablet PO daily with or without food	#28	
☐ **Harvoni®**	90mg/400mg tablet (ledipasvir/sofosbuvir)	Take 1 tablet PO daily with or without food	#28	
☐ **Mavyret™**	100mg/40mg tablet (glecaprevir/pibrentasvir)	Take 3 tablets PO daily with food	4 weeks	
☐ **Sovaldi®**	400mg tablet (sofosbuvir)	Take 1 tablet PO daily with or without food	#28	
☐ **Vosevi™**	400mg/100mg/100mg tablet (sofosbuvir/velpatasvir/voxilaprevir)	Take 1 tablet PO daily with food	#28	
☐ **Zepatier™**	50mg/100mg (elbasvir/grazoprevir)	Take 1 tablet PO daily with or without food	#28	
☐ **Ribavirin**	☐ 200mg tablets ☐ 200mg capsules	☐ 1400mg - 600mg PO every morning and 800mg PO every evening ☐ 1200mg - 600mg PO every morning and 600mg PO every evening ☐ 1000mg - 400mg PO every morning and 600mg PO every evening ☐ 800mg - 400mg PO every morning and 400mg PO every evening ☐ Other: _____- _____PO every morning and _____PO every evening	4 weeks	
☐ **Other:**				

By signing this form and utilizing our services, you are authorizing FountainRx and/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:**_____