Appalachian Specialty PHARMACY

Hepatitis C Enrollment Form

Phone (828)222-4269 Fax (828) 785-1437
932 Hendersonville Road Suite 106
Asheville, NC 28803

DATE:_____ NEEDS BY DATE: _____ SHIP TO: ☐ PATIENT ☐ OFFICE- FIRST DOSE ☐ OFFICE – ALL DOSES ☐ OTHER _____

INSURANCE: PLEASE FAX BOTH SIDES OF PRESCRIPTION CARD AND MEDICAL CARD(S)

PATIENT INFORMATION

Patient Name		Date of Birth
Address		
City	State	Zip
Phone	Alt Phone	Sex: ☐ Male ☐ Female ☐ other:
Social Security	Gender Identity ☐ M ☐ F ☐ Transgender ☐other:	

PRESCRIBER INFORMATION

Prescriber Name		
Prescriber Type ☐ Physician (MD or DO) ☐ Nurse Practitioner ☐ Physician's Assistant		
Supervising Physician (if prescriber is a NP or PA)		
DEA #	NPI#	TAX ID#
Address		
City	State	Zip
Phone	Fax	
Contact Person	Preferred Method of contact ☐Phone ☐Fax ☐ Other	

CLINICAL INFORMATION

Diagnosis/ ICD10: ☐ B18.2 Chronic Hepatitis ☐ B17.10 Acute Hepatitis C ☐ Z94.4 Liver Transplant ☐ B20 HIV ☐ HBV ☐ OTHER : DX Code:

Genotype ☐ 1a (☐NSSA RAVs) ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐5 ☐ 6	**Responder Status: ☐ Naïve ☐Relapsed ☐ Partial Responder ☐ Non-Responder**
Patient Height Patient Weight	Patient Allergies
Previous Therapy	Dates of Therapy
Viral Load	Load Date
Fibrosis Stage ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4	**☐ Cirrhosis ☐ Decompensated ☐ Liver Transplant Candidate ☐ Solid Organ Transplant Recipient**

PRESCRIPTION INFORMATION			DURATION	QTY	REFILLS	COMPLIANCE PACKAGING
☐ Daklinza (daclatasvir)	☐ 30 mg ☐ 60 mg	Take _____ mg PO QD with or without food Administer with sofosbuvir	_____Weeks	4 week supply	_____	☐ Yes ☐ No
☐ Epclusa	400mg/ 100mg Tablet (sofosbuvir/velpatasvir)	Take one tablet PO QD with or without food	_____Weeks	4 week supply	_____	☐ Yes ☐ No
☐ Harvoni	90mg/ 400mg Tablet (ledipasvir/sofosbuvir)	Take one tablet PO QD with or without food	_____Weeks	4 week supply	_____	☐ Yes ☐ No
☐ Mavyret	100mg/ 40m Tablet (glecaprevir/pibrentasvir)	Take three tablets PO QD with food	_____Weeks	4 week supply	_____	☐ Yes ☐ No
☐ Sovaldi	400mg Tablet (sofosbuvir)	Take one tablet PO once daily with or without food	_____Weeks	4 week supply	_____	☐ Yes ☐ No
☐ Vosevi	400mg/ 100mg/ 100 mg Tablet (sofosbuvir/velpatasvir/voxilaprevir)	Take one tablet PO QD with food	_____Weeks	4 week supply	_____	☐ Yes ☐ No
☐Zepatier	50 mg/ 100 mg Tablet (elbasvir/grazoprevir)	Take one tablet PO QD with or without food	_____Weeks	4 week supply	_____	☐ Yes ☐ No
☐Ribavirin	☐200mg tablets ☐200mg capsules ☐200mg Moderiba ☐Moderibe Dose Pack ☐Ribapack	☐ 1200mg: 600mg PO QAM, 600mg PO QPM ☐ 1000mg: 600mg PO QAM, 400mg PO QPM ☐ 800mg: 400mg PO QAM, 400mg PO QPM ☐ 600mg: 400mg PO QAM, 200mg PO QPM ☐Other:___mg take:_____ POQAM& ____ PO QPM	_____Weeks	4 week supply	_____	☐ Yes ☐ No
☐ Other		_____	_____Weeks	_____	_____	

Special Comments:

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

_____ _____ _____ _____

Dispense as Written Date Substitution Permitted Date