HEPATITIS C ENROLLMENT FORM

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NPI: 1588300545

Ship to: ☐ Patient ☐ Physician ☐ Other

PATIENT INFORMATION

Patient Name (Last, First): _____ DOB: _____ Gender: ☐Female ☐Male
Address: _____City/State/Zip:_____
SSN: _____ Allergies: _____
Phone: _____ Alt Phone: _____
Email: _____ Preferred Contact: ☐Phone ☐ Email
Parent/Caregiver/Legal Guardian Name (Last, First): _____
Relationship to Patient: _____ Phone: _____

INSURANCE INFORMATION: Please fax copy of prescription and insurance cards with this form (front and back)

CLINICAL INFORMATION

Diagnosis (ICD-10): Date of Dx: _____

☐ B18.2 Chronic Viral Hepatitis C ☐ Other Code: _____ Description _____

Genotype: ☐ 1A ☐ 1B ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Other:_____ Viral Load: _____ RNA Test Date: _____

☐ No Cirrhosis ☐ Compensated Cirrhosis ☐ Decompensated Cirrhosis Fibrosis Score: _____
HIV Co-Infected: ☐ Yes ☐ No Weight: _____ lb/kg Height: _____ in/cm

Is patient: ☐ Naïve ☐ Partial Responder ☐ Non-Responder ☐ Relapser; Last Therapy Date: _____ Product Name: _____

Is patient currently on HCV therapy? ☐ No ☐ Yes Therapy Start Date: _____ Product Name: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QTY	REFILLS
Duration of Therapy: ☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ 24 weeks				
☐ Epclusa	Fixed-dose combination tablet of 400mg sofosbuvir / 100mg velpatasvir	Take 1 tablet by mouth once daily	28 day supply	____
☐ Harvoni	Fixed-dose combination tablet of 90mg ledipasvir / 400mg sofosbuvir	Take one tablet by mouth daily with or without food. Do not take within 4 hours of antacids	28 day supply	____
☐ Mavyret	Fixed-dose combination tablet of 100mg glecaprevir / 40mg pibrentasvir	Take 3 tablets by mouth once a day with food	28 day supply	____
☐ Vosevi	Fixed-dose combination tablet of 400mg sofosbuvir / 100mg velpatasvir / 100mg voxilaprevir	Take 1 tablet by mouth once a day with food	28 day supply	____

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____
Address: _____
City: _____ Zip: _____ Phone: _____ Fax: _____
Contact Person: _____ Contact Phone: _____

PRESCRIBER SIGNATURE (DO NOT STAMP) *NY & IA prescriptions must be submitted via escript*

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute

Prescriber's Signature: _____
Date: _____

May Substitute / Product Selection Permitted / Substitution Permissible

Prescriber's Signature: _____
Date: _____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize Brigent Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA requests as my signature.