

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: <input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> 16 weeks <input type="checkbox"/> 24 weeks				
<input type="checkbox"/> Epclusa	Fixed-dose combination tablet of 400mg sofosbuvir / 100mg velpatasvir	Take 1 tablet by mouth once daily	28 day supply	_____
<input type="checkbox"/> 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	_____
<input type="checkbox"/> Mavyret	Fixed-dose combination tablet of 100mg glecaprevir / 40mg pibrentasvir	Take 3 tablets by mouth once a day with food	28 day supply	_____
<input type="checkbox"/> 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)

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

May Substitute / Product Selection Permitted / Substitution Permissible

Prescriber's Signature: _____

Prescriber's Signature: _____

Date: _____

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.