elixir
SPECIALTY PHARMACY

Hepatitis C Enrollment Form
Phone: 877-437-9012 Fax: 877-309-0687

☐ New to Therapy
☐ Current Therapy

Patient Information

Patient Name: ____
Date of Birth: __________ Gender: _________ SS#____________________
Address: ____
City: ____________________State:_________Zip:_________________
Home Phone: __________________ Work Phone: __________________
Cell Phone: ________________ E-mail:_____________________________
Patient Weight: _____________kg /lbs Patient Height:
_____________in /cm
Please attach copy of front and back of patient's prescription ins. card(s) if applicable
Insurance Company Name: _____________________________________
Insurance Company Phone: ____________________________________
Policy holder:____
Policy holder Employer:_______________________________________
Relationship to Patient:______________________________________
ID# _________________________Group#_______________________

Prescriber Information

Practice/ Organization Name: ____
Physician Name: ____
Contact Person: __________________________ Contact's Phone: ____________________
Address:____ __________________________
City: _______________________________ State: _________________ Zip: _____________
Office Phone#:_____________________________ Office Fax#:_________________________
DEA#________________________________ NPI#______________________________
License#:___________________________ Medicaid UPIN#:___________________________
Physician Specialty: ____
Date Shipment Needed: ____
Ship to: ☐Patient ☐Prescriber ☐Other________________________________
Shipment Address: _________________________________ Attn: _______________________
City: _________________________State: _______________Zip:___________
If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

Diagnosis and Clinical Information

ICD-10 Diagnosis: ☐ B17.10 Acute Hepatitis C without hepatic coma ☐ B17.11 Acute Hepatitis C with hepatic coma ☐ B18.2 Chronic Viral Hepatitis C
☐ B19.20 Unspecified Viral hepatitis C without hepatic coma ☐ B20 HIV ☐ Other: ____________________ Description: ____________________________________
Co-infection: ☐ HIV ☐ HBV ☐ None Vaccinations Completed for Hepatitis A/B ☐ Yes ☐ No
Genotype: ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5/6 HCV RNA level: _____________ IU/ml Date Drawn:___/___/____
Metavir Score: ______☐ No Cirrhosis ☐ Compensated Cirrhosis ☐ Decompensated Cirrhosis Child-Pugh score:_________________________
Post-transplant: ☐ Yes ☐ No, if Yes please specify: _______________________ Renal impairment: ☐ Yes ☐ No
Previously treated for HCV? ☐ Yes ☐ No Prior treatment(s):____ Prior treatment(s) Date: ___________________________
Prior Treatment response: ☐ Partial ☐ Null ☐ Intolerant (specify): ____
For Zepatier genotype 1a patients, NS5A polymorphism present ☐ Yes ☐ No
For Epclusa genotype 3 Compensated Cirrhosis patients, baseline NS5A RAS Y93H presencd ☐ Yes ☐ No
Concurrent medications: ____
Patients Allergies: ____

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Updated December 2022

Patient Name: ________________________ **Patient Date of Birth:** ____________________

Prescriber Name: ________________________ **Phone:** ________________ **Date:** ____________

Prescriber Address:____

☐ **Epclusa®** (400mg/100mg sofosbuvir/velpatasvir tablets) ☐ **Epclusa®** (200mg/50mg sofosbuvir/velpatasvir tablets)
Take 1 tablet by mouth once daily with or without food for _______ weeks.

☐ **Epclusa®** (200mg/50mg sofosbuvir/velpatasvir pellets) ☐ **Epclusa®** (150mg/37.5mg sofosbuvir/velpatasvir pellets)
Mix ______ packet(s) of oral pellets with one or more spoonfuls of soft food and take by mouth once daily for _______ weeks.
Pour the entire contents of ______ packet(s) directly into the mouth and swallow without chewing once daily for _______ weeks.

☐ **Harvoni®** (90mg/400mg ledipasvir/sofosbuvir tablets) ☐ **Harvoni®** (45mg/200mg ledipasvir/sofosbuvir tablets)
Take 1 tablet by mouth once daily with or without food for _______ weeks.

☐ **Harvoni®** (45mg/200mg ledipasvir/sofosbuvir granules) ☐ **Harvoni®** (33.75mg/150mg ledipasvir/sofosbuvir granules)
Mix ______ packet(s) of oral granules with one or more spoonfuls of soft food and take by mouth once daily for _______ weeks.
Pour the entire contents of ______ packet(s) directly into the mouth and swallow without chewing once daily for _______ weeks.

☐ **Mavyret®** (100mg/40mg glecaprevir/pibrentasvir tablets)
Take Three (3) tablets by mouth once daily with food for _______ weeks.

☐ **Mavyret®** (50mg/20mg glecaprevir/pibrentasvir granules)
Mix ______ packets with a small amount of soft food and take by mouth once daily with food for _______ weeks.

☐ **Sovaldi®** (400mg sofosbuvir tablets) ☐ **Sovaldi®** (200mg sofosbuvir tablets)
Take 1 tablet by mouth once daily for _______ weeks.

☐ **Sovaldi®** (200mg sofosbuvir pellets) ☐ **Sovaldi®** (150mg sofosbuvir pellets)
Mix ______ packet(s) of oral pellets with one or more spoonfuls of soft food and take by mouth once daily for _______ weeks.
Pour the entire contents of ______ packet(s) directly into the mouth and swallow without chewing once daily for _______ weeks.

☐ **Viekira Pak®** (250mg/12.5mg/75mg/50mg Dasabuvir/Ombitasvir/Paritaprevir/Ritonavir)
Take as directed on the Pak for 12 weeks.

☐ **Vosevi®** (400mg/100mg/100mg sofosbuvir/velpatasvir/voxilaprevir)
Take 1 tablet by mouth once daily with or without food for 12 weeks.

☐ **Zepatier™** (50mg/100mg elbasvir/grazprevir).
Take 1 tablet by mouth once daily for ______ weeks.

☐ **Ribavirin Rx:**

Patient Weight: ______________________kg/lbs Patient Height: ________________in/cm Hgb:______________g/dL

Dispense: 28 day supply of medication with ☐ 0 ☐1 ☐ 2 ☐ Other: _______ Refills

Prescriber Signature: *X*____

If Brand required "Dispense as Written" must be handwritten

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