HepCare Specialty Pharmacy
Committed • Accessible • Reliable • Experienced

HEPATITIS C - PRESCRIBER GUIDED ENROLLMENT FORM

DATE: _____
DATE NEEDED: _____
SHIP TO: ☐ PATIENT ☐ OFFICE

FAX THIS FORM TO: 512-490-6515
2200 Park Bend Drive, Bldg 1,
Suite 300, Austin, Texas, 78758
Phone: [512] 381-1708 • Toll Free [855] 241-6658

PATIENT INFO

NAME _____ E-MAIL _____ DOB _____ ☐ MALE ☐ FEMALE
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME TELEPHONE _____ MOBILE PHONE _____ SS# _____

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK) • • • • • • • • • • • • • • • PRESCRIPTION INFORMATION • • • • • • • • • • • • • • •

CLINICAL INFORMATION

DIAGNOSIS CODE (ICD-10)

Date of Diagnosis: _____
☐ B18.2 Chronic Hepatitis C

CLINICAL INFORMATION

Weight _____ kg/lb Height _____ cm/in
Allergies _____ ☐ NKDA
☐ HCV RNA (Baseline) _____ IU/ml
☐ HCV RNA (after ____ wks Tx) IU/mL
Date of Lab _____
HCV Genotype: ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
Length of TX: _____
Pre-treatment ALT: _____
Has patient been previously treated for HCV?
Hepatitis C ? ☐ Yes ☐ No
If Yes, ☐ PegIFN/RBV ☐ PegIFN/RBV/PI ☐ NS5A ☐ NS3/4A
Other Medications: _____
_____
Liver Biopsy Results: _____ Date: _____
Fibroscan Results: _____ Date: _____
FIB-4: _____ CTP Score: _____

ADVANCED DISEASE CHARACTERISTICS

☐ Advanced Fibrosis (Met F3)
☐ Compensated cirrhosis (Met F4)
☐ Post-liver transplant ☐ Proteinuria
☐ Nephrotic syndrome ☐ Glomerulonephritis
☐ Type 2/3 essential mixed cyroglobulinemia w/ end-organ manif. (eg, vasculitis)
☐ Decompensated Cirrhosis
☐ HCC – Hepatocellular Carcinana

MODERATELY ADVANCED DISEASE CHARACTERISTIC

☐ Fibrosis (Met F2) ☐ HIV co-infection*
☐ Hepatitis B co-infection ☐ Debilitating fatigue
☐ Type 2 Diabetes mellitus
☐ Porphyria cutanea tarda
☐ Other co-existent liver disease (eg, NASH)
* For patients w/ HCV/HIV-1 coinfection treat as mono-infection.

OTHER DISEASE CHARACTERISTICS

☐ Metavir F0-F1
☐ NS5A Resistance ☐ A30K

PRESCRIPTION INFO

OTHER

☐ _____ ____mg
Directions: _____
_____
Qty: ☐ _____ ☐ Refills: _____

MAVYRET™

☐ **MAVYRET™** 300mg/120mg Tab
Directions:
☐ 3 tabs po ONCE daily w/ food.
Qty: ☐ 28 Day Supply Supply (4 week carton)
☐ 56 Day Supply (8 week carton)
☐ Other _____

CHOOSE PATIENT TYPE: Tx Duration	Refills
☐ TX NAÏVE - GTP1-6: w/o cirrhosis — 8 Wks	1
☐ TX NAÏVE-GTP1-6: w/ compensated cirrhosis (Child-Pugh A) — 12 Wks	2
☐ TX EXPER. - GTP1: prior Tx w/ an NS5A inhibitor (w/o an NS3/4A PI) w/o cirrhosis or w/ compensated cirrhosis (Child-Pugh A) — 16Wks	3
☐ TX EXPER. - GTP1: prior tx w/ an NS3/4A PI (w/o a NS5A inhibitor) w/o cirrhosis or w/ compensated cirrhosis (Child-Pugh A) — 12 Wks	2
☐ TX EXPER. - GTP1,2,4,5, or 6: PRS* w/o cirrhosis — 8 Wks	1
☐ TX EXPER. - GTP1,2,4,5, or 6: PRS* w/ compensated cirrhosis (Child-Pugh A) — 12 Wks	2
☐ TX EXPER. - GTP3: PRS* w/o cirrhosis or w/ compensated cirrhosis (Child-Pugh A) — 16 Wks	3

**PRS = prior treatment experience with regimens containing interferon, peg interferon, ribavirin and/or sofosbuvir, but no prior Tx Experience with an hcv NS3/4A or NS5A inhibitor.*

SOVALDI/RIBAVIRIN

☐ **1. SOVALDI®** 400mg
Directions: ☐ 1 tab po QD ☐ Qty:
☐ 28 Day Supply ☐ _____

☐ **2. RIBAVIRIN:** Please choose product under 'RIBAVIRIN'

CHOOSE PATIENT TYPE: Tx Duration	Refills
☐ GTP 2: TX NAÏVE or TX EXPER.; w/o cirrhosis or w/ compensated cirrhosis (Child-Pugh A) — 12 Wks	2
☐ GTP 3: TX NAÏVE or TX EXPER.; w/o cirrhosis or w/ compensated cirrhosis (Child-Pugh A) — 24 Wks	5

HARVONI®

☐ **HARVONI®** 90mg/400mg
Directions: ☐ 1 tab po QD
Qty: ☐ 28 Day Supply ☐ _____

CHOOSE PATIENT TYPE: Tx Duration	Refills
☐ GTP 1: TX NAÏVE w/o cirrhosis or w/ compensated cirrhosis (Child-Pugh A) — 12 Wks	2
☐ GTP 1: TX EXPER. w/o cirrhosis — 12 Wks	2
☐ GTP 1: TX EXPER. w/ compensated cirrhosis (Child-Pugh A) — 24 Wks	5
☐ GTP 1: TX NAÏVE or TX EXPER. w/ decompensated cirrhosis (Child-Pugh B or C) (add ribavirin) — 12 Wks	2
☐ GTPs 1 or 4: TX NAÏVE or TX EXPER. liver transplant recipients w/o cirrhosis, or w/ compensated cirrhosis (Child-Pugh A) (add ribavirin) — 12 Wks	2
☐ GTPS 4, 5, or 6: TX NAÏVE or TX EXPER. w/o cirrhosis or w/ compensated cirrhosis (Child-Pugh A) — 12 Wks	2
☐ GTP1: TX NAÏVE w/o cirrhosis w/ HCV RNA **<6 million IU/mL*** — 8 Wks	1

**HARVONI for 8 Wks may be considered in treatment-naïve genotype 1 patients w/o cirrhosis who have a pretreatment HCV RNA less than 6 million IU/mL (not recommended for HIV coinfection, African American patients, or those w/ IL28B polymorphism CT or TT).*

ZEPATIER®

☐ **ZEPATIER** 100mg/50mg tab.
Directions: ☐ 1 tab po QD
Qty: ☐ 28 Day Supply ☐ _____

CHOOSE PATIENT TYPE: Tx Duration	Refills
☐ GTP 1a: TX NAÏVE or PegINF/RBV - Exper. w/o baseline NS5A polymorphisms* — 12 Wks	2
☐ GTP 1a: TX NAÏVE or PegINF/RBV - Exper. w/ baseline NS5A polymorphisms* (add ribavirin) — 16 Wks	3
☐ GTP 1b: TX NAÏVE or PegINF/RBV-Exper. — 12 Wks	2
☐ GTP 1a or 1b: treatment PegINF/RBV/PI**- EXPER. (add ribavirin) — 12 Wks	2
☐ GTP 4: TX NAÏVE — 12 Wks	2
☐ GTP 4: PegINF/RBV-EXPER. (add ribavirin) — 16 Wks	3

☐ **RIBAVIRIN:** *If approp, please choose product under 'RIBAVIRIN' *Polymorphisms at amino acid positions 28, 30, 31, or 93. **Prior protease inhibitor (PI) Tx includes simeprevir, telaprevir, or boceprevir.*

VOSEVI™

☐ **VOSEVI™**
400mg / 100mg / 100mg tab.
Directions: ☐ Take 1 tab po QD w/ food
Qty: ☐ 28 Day Supply ☐ _____

CHOOSE PATIENT TYPE: Tx Duration	Refills
☐ GTP 1-6: TX EXPER. w/ an NS5A inhibitor. w/o cirrhosis or w/ COMPENSATED cirrhosis (Child-Pugh A) — 12 Wks	2
☐ GTP 1a or 3: TX EXPER. w/ sofosbuvir w/o an NS5A inhibitor w/o cirrhosis or w/ COMPENSATED cirrhosis (Child-Pugh A) — 12 Wks	2

VIEKIRA / VIEKIRA PAK™

☐ **VIEKIRA XR™**
200mg / 50mg / 33.33mg / 8.33mg Tab
☐ **VIEKIRA PAK™**
75mg / 50mg / 25mg / 12.5mg Tab
Directions:
☐ Take as directed on PAK po w/ food.
Qty: ☐ 28 Day Supply ☐ _____

CHOOSE PATIENT TYPE: Tx Duration	Refills
☐ GTP 1a: no cirrhosis (add ribavirin) — 12 Wks	2
☐ GTP 1a: w/ cirrhosis (add ribavirin)* ** *12 Wks may be considered based on prior TX history* — 24 Wks	5
☐ GTP 1b: no cirrhosis — 12 Wks	2
☐ GTP 1b: w/ cirrhosis — 12 Wks	2
☐ Post-liver transplant, GTP 1a or 1b (add ribavirin) — 24 Wks	5

☐ *RIBAVIRIN: If approp, please choose product under 'RIBAVIRIN'*

TECHNIVIE™

☐ **TECHNIVIE™**
75mg / 50mg / 12.5mg Tab
Directions:
☐ Take as directed on PAK po w/ food.
Qty: ☐ 28 Day Supply ☐ _____

CHOOSE PATIENT TYPE: Tx Duration	Refills
☐ GTP 4: TX NAÏVE or EXPER., w/o cirrhosis or w/ compensated cirrhosis (Child Pugh A)(add ribavirin)* — 12 Wks	2

**Note: Technivie w/o riba can be used in pts who cannot tolerate ribavirin*

☐ *RIBAVIRIN: If approp, please choose product under 'RIBAVIRIN'*

EPCLUSA®

☐ **EPCLUSA®** 400mg /100mg
Directions: ☐ 1 tab po QD
Qty: ☐ 28 Day Supply ☐ _____

CHOOSE PATIENT TYPE: Tx Duration	Refills
☐ GTP 1-6: TX NAÏVE or TX EXPER. w/o cirrhosis or w/ COMPENSATED cirrhosis (Child-Pugh A) — 12 Wks	2
☐ GTP 1-6: TX NAÏVE or TX EXPER. w/ DECOMPENSATED cirrhosis or post-transplant (Child -Pugh B or C) (add ribavirin) — 12 Wks	2

RIBAVIRIN

☐ **RIBAPAK®**
☐ **MODERIBA™ PACK**
☐ **RIBAVIRIN**
200mg ☐ Tablets ☐ Capsules
Qty: ☐ 28 Day Supply ☐ _____

CHOOSE PATIENT TYPE:	Refills
☐ <75kg/165lbs 1000mg/day Take 600mg po qAM and 400mg po qPM	
☐ ≥75kg/165lbs 1200mg/day Take 600mg po qAM and 600mg po qPM	
☐ Other _____	

DAKLINZA™/SOVALDI®

☐ **1. DAKLINZA™**
☐ 30mg ☐ 60mg ☐ 90 mg ☐ _____
Directions: ☐ 1 tab po QD
Qty: ☐ 28 Day Supply ☐ _____

☐ **2. SOVALDI®** 400mg
Directions: ☐ 1 tab po QD
Qty: ☐ 28 Day Supply ☐ _____

CHOOSE PATIENT TYPE: Tx Duration	Refills
☐ GTP 3: TX NAÏVE or TX EXPER.; no cirrhosis — 12 Wks	2
☐ GTP 3: TX NAÏVE or TX EXPER.; w/ cirrhosis or post-transplant (add ribavirin) — 12 Wks	2
☐ GTP 1*: TX NAÏVE or TX EXPER.; no cirrhosis — 12 Wks	2
☐ GTP 1*: TX NAÏVE or TX EXPER.; w/ COMPENSATED cirrhosis (Child-Pugh A) — 12 Wks	2
☐ GTP 1*: TX NAÏVE or TX EXPER.; w/ DECOMPENSATED (Child-Pugh B or C) cirrhosis or post-transplant (add ribavirin) — 12 Wks	2

** Consider NS5A resistance testing in HCV Genotype 1a infected patients w/ cirrhosis.*

PRESCRIBER INFORMATION

Prescriber's Name: _____ Contact Person: _____
Telephone: _____ Fax: _____ Email: _____
Office Address: _____ City: _____ State: _____ Zip: _____
NPI # : _____ DEA # : _____ TAX ID # : _____ Medicaid Provider # : _____

_____ _____ * _____
PRESCRIBER'S SIGNATURE (DATE) *IF BRAND DRUGS ARE PREFERRED, HANDWRITE **"BRAND MEDICALLY NECESSARY"** ABOVE

I authorize the Pharmacy noted above and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Form: ©REF--HepPreGuid-HCV-E
HepCare
-5161-08-14-2017