Star Discount Pharmacy specialty care

Hepatitis C Virus

Call: (877) 883-1392 Fax: (256) 429-2221

Patient Information: Name: ____________________ DOB: __________ Gender: ○M ○F
Address: ______________________________ City: ________________ State: ______ Zip: ____________
Phone: ________________ Alt. Phone: ________________ Email: ____________________________ Ht: ______ Wt: ______
Care Giver: __________________________ Allergies: No Known See Attached Charts Other: __________________________

Prescriber Information: Last 4 of SSN:
Name: ______________________________ NPI: ____________________ Phone: __________________ Fax: ________________
Address: ______________________________ City: ________________ State: ______ Zip: __________ Office Contact: ______________

Statement of Medical Necessity **(Please Attach All Medical Documentation)**

Diagnostic Information

Date of Diagnosis:__________ **ICD-10**: ___________ **Race**: __________
Genotype: ________ **Subtype**: _________ **Q80K**: ○Positive ○Negative (For Genotype 1a)
Patient Status: ○Naïve ○Partial Responder ○Non-responder ○Null-responder ○Relapser
Duration of Previous Therapy: _____ Weeks From: ____________ To: ____________
Cirrhosis: ○No ○Yes **If Yes**: ○Compensation ○Decompensated
History of Liver Biopsy? ○No ○Yes *(If Yes, Please Attach Results)*
○**Fibrosure** or ○**Fibroscan** Results: ______________________
Extra-Hepatic Manifestations: ○Ascites ○Hepatic Encephalopathy ○Thrombocytopenia
○Other: ______________________ **Does patient need liver transplant?** ○Yes ○No
History of prior liver decompensation? ○Yes ○No
HBsAg and anti-HBc Test: ○Positive ○Negative Date: ______________

Labs

ALT: HGB:
AST: HCV RNA:
PLT: SCr:
NS5A Resistance Assay: Date:

Medication List and Contraindications

○Attach Medication List
○Is patient interferon eligible? ○No ○Yes
○Anxiety ○Depression ○Pulm Abnormalities
○Renal Insufficiency ○Other: ___________

Product Delivery: ○ Patient's Home ○ Physician's Office ○Pharmacy to Coordinate
Duration of Therapy: ○8 weeks ○ 12 weeks ○24 weeks ○ Other: ______________

Medication	Dosage & Strength	Directions	Qty	Ref
○Epclusa	○400/100mg Tablets ○200/50mg Tablets	○Adult: Take one tablet by mouth daily with or without food Pediatric: Patients 6 Years and Older ○**>30kg:** Take one 400/100mg tablet by mouth daily with or without food OR Take two 200/50mg tablets by mouth daily with or without food. ○**17-29kg:** Take one 200/50mg tablet by mouth daily with or without food.	28 28 56 28	
○Harvoni	○45/200mg Tablets ○45/200mg Oral Pellets ○33.75/150 Oral Pellets ○90/400mg Tablets	○Adult: Take one 45/200mg tablet by mouth daily with or without food. Pediatric: Patients 3 Years and Older ○**>35kg:** Take one 90/400mg tablet by mouth daily with or without food OR take two 45/200mg tablets/pellets by mouth daily with or without food. ○**17-34kg:** Take one 45/200mg tablet/packet of pellets by mouth daily with or without food ○**<17kg:** Take one 33.75/150mg packet of pellets by mouth daily with or without food	28 56 28 28	
○ Mavyret	○100/40mg Tablet	○Take three tablets by mouth once daily with food	1 Carton	
○ Sovaldi	○200mg Tablets ○400mg Tablets ○150mg Oral Pellets ○200mg Oral Pellets	○Adult: Take one 400mg tablet by mouth daily with or without food Pediatric: Patients 3 Years and Older ○**>35kg:** Take one 400mg tablet by mouth daily with or without food OR take two 200mg tablets/pack of pellets by mouth daily with or without food ○**17-34kg:** Take one 200mg tablet by mouth daily with or without food ○**<17kg:** Take one 150mg packet of pellets by mouth daily with or without food	28 56 28 28	
○Vosevi	○400/100/100mg Tablets	○ Take one tablet by mouth once daily with food	28	
○Moderiba Dose Pack ○Ribasphere Riba Pack	○ 600mg Per Day ○ 800mg Per Day ○ 1000mg Per Day ○ 1200mg Per Day	○ Take 200mg tablet every morning/400mg tablet every evening ○ Take 400mg tablet every morning/400mg tablet every evening ○ Take 600mg tablet every morning/400mg tablet every evening ○ Take 600mg tablet every morning/600mg tablet every evening		
○Moderiba ○Ribasphere ○Ribavirin	○ 200mg Tablets ○ 200mg Capsules	○ Take ______ tabs/caps by mouth every morning, and ○ Take ______ tabs/caps by mouth every evening		
○Xifaxan	○ 550mg Tablets	○ Take one tablet by mouth twice daily with or without food	60	
○Zepatier	○50/100mg Tablets	○ Take one tablet by mouth daily with or without food	28	

Prescriber Signature (I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs)

Signature: __________________________ Signature:__________________________ Date: ______________
Substitution Permitted **Dispense as Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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