

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:
 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
<input type="radio"/> Eplusa	<input type="radio"/> 400/100mg Tablets	<input type="radio"/> Adult: Take one tablet by mouth daily with or without food	28	
	<input type="radio"/> 200/50mg Tablets	<input type="radio"/> Pediatric: Patients 6 Years and Older	28	
		<input type="radio"/> >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.	56	
		<input type="radio"/> 17-29kg: Take one 200/50mg tablet by mouth daily with or without food.	28	
<input type="radio"/> Harvoni	<input type="radio"/> 45/200mg Tablets	<input type="radio"/> Adult: Take one 45/200mg tablet by mouth daily with or without food.	28	
	<input type="radio"/> 45/200mg Oral Pellets	<input type="radio"/> Pediatric: Patients 3 Years and Older	56	
	<input type="radio"/> 33.75/150 Oral Pellets	<input type="radio"/> >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.	28	
	<input type="radio"/> 90/400mg Tablets	<input type="radio"/> 17-34kg: Take one 45/200mg tablet/packet of pellets by mouth daily with or without food	28	
		<input type="radio"/> <17kg: Take one 33.75/150mg packet of pellets by mouth daily with or without food	28	
<input type="radio"/> Mavyret	<input type="radio"/> 100/40mg Tablet	<input type="radio"/> Take three tablets by mouth once daily with food	1 Carton	
<input type="radio"/> Sovaldi	<input type="radio"/> 200mg Tablets	<input type="radio"/> Adult: Take one 400mg tablet by mouth daily with or without food	28	
	<input type="radio"/> 400mg Tablets	<input type="radio"/> Pediatric: Patients 3 Years and Older	56	
	<input type="radio"/> 150mg Oral Pellets	<input type="radio"/> >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	28	
	<input type="radio"/> 200mg Oral Pellets	<input type="radio"/> 17-34kg: Take one 200mg tablet by mouth daily with or without food	28	
		<input type="radio"/> <17kg: Take one 150mg packet of pellets by mouth daily with or without food	28	
<input type="radio"/> Vosevi	<input type="radio"/> 400/100/100mg Tablets	<input type="radio"/> Take one tablet by mouth once daily with food	28	
<input type="radio"/> Moderiba Dose Pack	<input type="radio"/> 600mg Per Day	<input type="radio"/> Take 200mg tablet every morning/400mg tablet every evening		
	<input type="radio"/> 800mg Per Day	<input type="radio"/> Take 400mg tablet every morning/400mg tablet every evening		
	<input type="radio"/> 1000mg Per Day	<input type="radio"/> Take 600mg tablet every morning/400mg tablet every evening		
<input type="radio"/> Ribasphere Riba Pack	<input type="radio"/> 1200mg Per Day	<input type="radio"/> Take 600mg tablet every morning/600mg tablet every evening		
<input type="radio"/> Moderiba	<input type="radio"/> 200mg Tablets	<input type="radio"/> Take _____ tabs/caps by mouth every morning, and		
	<input type="radio"/> Ribasphere	<input type="radio"/> Take _____ tabs/caps by mouth every evening		
	<input type="radio"/> Ribavirin			
<input type="radio"/> Xifaxan	<input type="radio"/> 550mg Tablets	<input type="radio"/> Take one tablet by mouth twice daily with or without food	60	
<input type="radio"/> Zepatier	<input type="radio"/> 50/100mg Tablets	<input type="radio"/> 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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