VITAL CARE RX

Tailored Therapy, Trusted Care

Hepatitis C Enrollment Form

Phone: (877)229-1724 | Fax: (877)229-1725

PATIENT INFORMATION

(Complete the following or send patient demographic sheet.)
Please fax copy of patient's insurance card including both sides

Name:_____

DOB:_____ Gender: M / F Height: _____Wt:_____

Address:_____

City, State, Zip:_____

Home Phone:_____

Alternate Phone:_____

Last 4 digits SS#:_____ Email: _____

PRESCRIBER INFORMATION

Prescriber Name: _____

State Lic. #: _____ NPI:_____

Facility Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Contact: _____

Phone: _____Email: _____

CLINICAL INFORMATION – STATEMENT OF MEDICAL NECESSITY

Diagnosis: ☐ B18.2 Hepatitis C ☐ K74.60 Cirrhosis ☑ Other – ICD 10: _____

Genotype: _____ Viral Load: _____ Viral Load Date: _____

Previous Treatment: ☐ Naïve ☐ Non-Response ☐ Relapse ☐ Null

Date of Previous Therapy/Prior meds: _____ HIV Co-Infection: ☐ Yes ☐ No

Other medications patient is currently taking: _____

Allergies: _____ Liver Biopsy Date: _____ Fibrosis Score: _____

Compensated Liver Disease: ☐ Yes ☐ No Cirrhosis: ☐ Yes ☐ No Liver transplant recipient ☐ Yes ☐ No Metavir Score: _____

Please include hard copies of: genotype, viral load, liver biopsy scans, CBC, CMP, HIV, PT/INR, H&P, NS5A resistance testing and pertinent office visit notes.

PRESCRIPTION INFORMATION

Medication	Directions	Quantity	Refills
Epclusa®	☐ Take one tablet daily with or without food Total duration of therapy _____ weeks	28 day supply	
Harvoni®	☐ Take one tablet daily with or without food Total duration of therapy _____ weeks	28 day supply	
Mavyret™	☐ Take 3 tablets by mouth once daily with food Total duration of therapy _____ weeks	28 day supply	
Sovaldi®	☐ Take one tablet daily with or without food Total duration of therapy _____ weeks	28 day supply	
Vosevi™	☐ Take one tablet daily with food Total duration of therapy ___12___ weeks	28 day supply	
Zepatier™	☐ Take 1 tablet by mouth daily with or without food ☐ NS5A resistance test included (only G1a pts) Total duration of therapy _____ weeks	28 day supply	
Ribavirin	☐ Sig: _____ <165lbs = 1000mg/day Total duration of therapy _____ weeks ☐ Sig: _____ >165lbs = 1200mg/day Total duration of therapy _____ weeks	28 day supply	

Ship medications to: ☐ Physician's Clinic ☐ Patient's Home ☐ Initial to Physician's Clinic/Refills to Patient's home

Prescriber Signature _____ Date _____ Brand Name Required? ☐ Yes

I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, financial treatment and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of this product to another pharmacy of the patient's choice or in the patient's insurer's provider network.