

# Hepatitis C Enrollment

Please Fax Completed Form To: 305-251-3878  
14447 Country Walk Dr • Miami, FL 33186 • tel 305-251-7414

PATIENT INFORMATION						
Patient Name		DOB		SS#		
Address			City	State	Zip	
Phone #		Alt Phone #		Email		
Allergies				Height	Weight	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> other:		Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> other:				
<i>Please fax a copy of both sides of Patient's Insurance, Medicaid, or Medicare Part D Card</i>						

CLINICAL INFORMATION					
Diagnosis / ICD10: <input type="checkbox"/> B18.2 Chronic Hepatitis C <input type="checkbox"/> B17.10 Acute Hepatitis C <input type="checkbox"/> Z94.4 Liver Transplant <input type="checkbox"/> B20 HIV <input type="checkbox"/> Other					
Genotype: <input type="checkbox"/> 1a <input type="checkbox"/> 1b <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6			Responder Status: <input type="checkbox"/> Naïve <input type="checkbox"/> Relapsed <input type="checkbox"/> Partial Responder <input type="checkbox"/> Non-Responder		
Previous Therapy			When?		
Viral Load		AST		ALT	
Fibrosis Score	Fibrosis Stage <input type="checkbox"/> F0 <input type="checkbox"/> F1 <input type="checkbox"/> F2 <input type="checkbox"/> F3 <input type="checkbox"/> F4		<input type="checkbox"/> Cirrhosis <input type="checkbox"/> Decompensated <input type="checkbox"/> Liver Transplant Candidate		
<i>In order to expedite the prior authorization process, please fax copies of the patient's most recent progress notes and lab work. Please include: CBC, Chemistry, HCV Viral Load, HCV Genotype, Fibrosis Score. For Medicaid patients, include Drug and Alcohol Screenings (within 30 days.)</i>					

PRESCRIPTION INFORMATION					SHIP TO: <input type="checkbox"/> Patient <input type="checkbox"/> Physician's Office	
Medication	Strength	Directions	Duration	Quantity	Refills	
<input type="checkbox"/> Daklinza™ (daclatasvir)	<input type="checkbox"/> 30mg tablets <input type="checkbox"/> 60mg tablets	Take _____mg PO QD with or without food <small>*administer with sofosbuvir</small>	_____ weeks	4 Week Supply	_____	
<input type="checkbox"/> Eplusa® (sofosbuvir/velpatasvir)	400mg / 100mg	Take one tablet PO QD with or without food	_____ weeks	4 Week Supply	_____	
<input type="checkbox"/> Harvoni® (ledipasvir/sofosbuvir)	90mg / 400mg	Take one tablet PO QD with or without food	_____ weeks	4 Week Supply	_____	
<input type="checkbox"/> Mavyret™ (glecaprevir/pibrentasvir)	100mg / 40mg	Take three tablets by mouth once daily with food	_____ weeks	4 Week Supply	_____	
<input type="checkbox"/> Olysio™ (simeprevir)	150mg capsule	Take one 150mg tablet PO QD with food	_____ weeks	4 Week Supply	_____	
<input type="checkbox"/> Sovaldi™ (sofosbuvir)	400mg tablets	Take one tablet PO QD with or without food	_____ weeks	4 Week Supply	_____	
<input type="checkbox"/> Technivie™	12.5mg / 75mg / 50mg	Take two tablets PO QD with food <small>*administer with ribavirin</small>	_____ weeks	4 Week Supply	_____	
<input type="checkbox"/> Viekira Pak™	Viekira Pak™	Take as Directed	_____ weeks	4 Week Supply	_____	
<input type="checkbox"/> Viekira XR™	Viekira XR™	Take as Directed	_____ weeks	4 Week Supply	_____	
<input type="checkbox"/> Vosevi™ (sofosbuvir/velpatasvir/voxilaprevir)	400mg / 100mg / 100mg	Take one tablet PO QD with food	_____ weeks	4 Week Supply	_____	
<input type="checkbox"/> Zepatier™ (elbasvir/grazoprevir)	50mg / 100mg	Take one tablet PO QD with or without food	_____ weeks	4 Week Supply	_____	
<input type="checkbox"/> Ribavirin	<input type="checkbox"/> 200mg tablets <input type="checkbox"/> 200mg capsules <input type="checkbox"/> 200mg Moderiba <input type="checkbox"/> Moderiba Dose Pack <input type="checkbox"/> Ribapak	<input type="checkbox"/> 1200mg: 600mg PO QAM, 600mg PO QPM <input type="checkbox"/> 1000mg: 600mg PO QAM, 400mg PO QPM <input type="checkbox"/> 800mg: 400mg PO QAM, 400mg PO QPM <input type="checkbox"/> 600mg: 400mg PO QAM, 200mg PO QPM <input type="checkbox"/> Other: _____mg: take _____ PO QAM and _____ PO QPM	_____ weeks	4 Week Supply	_____	
<input type="checkbox"/> Other: _____		_____		_____ weeks	_____	

PRESCRIBER INFORMATION			PREFERRED CONTACT METHOD: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Email		
Prescriber Name		Type: <input type="checkbox"/> MD/DO <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician's Assistant			
Office Contact		Supervising Prescriber (if applicable)			
Phone #	Fax #		Email		
Address		City	State	Zip	
NPI	DEA				
<small>Your signature authorizes the pharmacy and its representatives to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients. A generically equivalent drug product may be dispensed unless the prescriber writes "Brand Necessary" or "Brand Medically Necessary" on the face of the prescription. ICARE RX can only accept faxed prescriptions from a prescriber's office or original prescriptions from patients.</small>		_____ <b>Prescriber Signature</b>		_____ <b>Date</b>	