encore pharmacy

HEPATITIS C - ENROLLMENT

Fax to: 512-490-6515

DATE: _____
DATE NEEDED: _____

SHIP TO: ☐ PATIENT ☐ OFFICE

PHARMACY LOCATION
Phone: 512-381-1708
Toll Free: 855-241-6658
11209 Metric Blvd., Suite B4
Austin, TX 78758

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 Virus (HCV)

☐ Other _____

CLINICAL INFORMATION

Weight_____kg/lb

Height_____cm/in

Allergies _____ ☐ NKDA

Genotype: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6

Subtype: ☐a ☐b ☐a/b ☐NA

Cirrhosis: ☐Y ☐N

If Y: ☐ Compensated ☐Decompensated

Liver Fibrosis: ☐F0 ☐F1 ☐F2 ☐F3 ☐F4

Post Liver Transplant : ☐Y ☐N

☐ Baseline HCV RNA_____IU/ml

Date of Lab _____

Co-Infection status: ☐HIV ☐HBV ☐N/A

Treatment Naïve: ☐Y ☐N

If No:

Prior HCV Treatment:

Dates:_____ Drug Name_____

Duration of Treatment _____

☐ Incomplete ☐ Partial

☐ Non-Response ☐ Relapse

Dates:_____ Drug Name_____

Duration of Treatment _____

☐ Incomplete ☐ Partial

☐ Non-Response ☐ Relapse

Expected Duration of Therapy

☐ 8 Weeks ☐ 12 Weeks

☐ 16 Weeks ☐ 24 Weeks

EPCLUSA®

☐ **EPCLUSA®** *(sofosbuvir and velpatasvir)*
400mg /100mg Tablet
Directions:
☐ Take 1 tablet PO QD with or without food
Qty: ☐ 28 **Refills:** ☐ _____

EPCLUSA® PEDIATRIC

☐ **EPCLUSA®** 200mg /50mg Tablet
Directions:
☐ Take 1 tablet PO QD with or without food
Qty: ☐ 28 **Refills:** ☐ _____

HARVONI®

☐ **HARVONI ®** *(ledipasvir and sofosbuvir)*
90/400mg Tablet
Directions:
☐ Take 1 tablet PO QD with or without food
Qty: ☐ 28 **Refills:** ☐ _____

HARVONI® PEDIATRIC

☐ **HARVONI®** ☐ 90/400 mg Tablet
☐ 45/200 mg Pellet ☐ 33.75/150mg Pellet
Directions:
☐ Take 1 tablet PO QD with or without food
☐ Take the contents of 1 packet PO QD with or without food
Qty: ☐ 28 Tablets ☐ 28 Pellet Packets
Refills: ☐ _____

MAVYRET™

☐ **MAVYRET™** 100mg/40mg Tablet
Directions: ☐ Take 3 tablets PO QD with food.
Qty: ☐ 84 Tablets **Refills:** ☐ _____

MAVYRET™ PEDIATRIC

☐ **MAVYRET™**
☐ 100/40 mg Tablet ☐ 50/20 mg Pellet
Directions: ☐ Take 3 tablets PO QD with food
☐ Take the contents of ____ packets PO QD with food
Qty: ☐ 1 month supply **Refills:** ☐ _____

SOVALDI®

☐ **SOVALDI™** 400mg Tablet
Directions: ☐ Take 1 tablet PO QD with or without food
Qty: ☐ _____ **Refills:** ☐ _____

VOSEVI™

☐ **VOSEVI™**
400mg / 100mg / 100mg Tablet
Directions:
☐ Take 1 tablet PO QD with food
Qty: ☐ 28 **Refills:** ☐ _____

ZEPATIER™

☐ **ZEPATIER™** 50/100 mg Tablet
Directions:
☐ Take 1 tablet PO QD with or without food
Qty: ☐ 28 **Refills:** ☐ _____
NS5A polymorphism present ☐ Y ☐ N

RIBAVIRIN

☐ **RIBAVIRIN:**
☐ 200mg Capsule ☐ 200mg Tablet
Directions:
☐ Take _____ tabs/caps PO q am and _____ tabs/caps q pm for a total of _____ mg daily with food.
Qty: ☐ _____ Tablets / Capsules
Refills: ☐ _____

XIFAXAN®

☐ **XIFAXAN®:** ☐ 550mg
Directions: ☐ Take 1 Tab PO BID
Qty: ☐ 60 **Refills:** ☐ _____

OTHER

☐ _____
Directions: ☐ _____
_____
Qty: ☐ _____ **Refills:** ☐ _____

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--HCV
Encore 83
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