HEPATITIS C ENROLLMENT

Patient Information

Phone:
Fax:
Toll Free:

Patient Information

Patient: _____

SS#: _____ DOB: _____ ☐ Male ☐ Female

Patient First Name: _____ Patient Last Name: _____ Caregiver: _____

Address: _____ City: _____ State: _____ Zip: _____

Best Phone #: _____ ☐ Cell Alternate Phone #: _____ ☐ Cell

Email: _____ Weight: _____ kgs or lbs (circle one) Recorded Date: _____

Allergies: _____ Comorbidities: _____

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

Medical Assessment

Complete Entire Section or Fax Lab Report including Genotype/Subtype

Diagnosis: ☐ 070.54 HCV (Chronic) Genotype: _____ Subtype: _____

Previously treated for HCV? ☐ No ☐ Yes # of weeks: _____

☐ Relapsed ☐ Partial Response ☐ Null Response

Liver biopsy done? ☐ No ☐ Yes Date: _____ Result: _____

Lab	Result	Date
Hgb		
ALT		
AST		
HCV RNA		

Interferon

PEG-INTRON ☐ **REDIPEN** ☐ **VIAL**

Weight kg (lb)	Dosing (based on 1.5 mcg/kg/wk with Ribavirin)
<40 (<88)	☐ 50mcg (0.5mL) Sub-Q weekly
40-50 (88-111)	☐ 64mcg (0.4mL) Sub-Q weekly
51-60 (122-133)	☐ 80mcg (0.5mL) Sub-Q weekly
61-75 (134-166)	☐ 96mcg (0.4mL) Sub-Q weekly
76-85 (134-187)	☐ 120mcg (0.5mL) Sub-Q weekly
>85 (>187)	☐ 150mcg (0.5mL) Sub-Q weekly

Qty: 4 doses (28 days) Refill #: _____

Ribavirin

RIBASPHERE (RIBAVIRIN GEQ) 200mg

☐ **Tablet** or ☐ **Capsule**

☐ 400 mg q AM and 200 mg q PM Qty: 84 Refill: _____

☐ 400 mg q AM and 400 mg q PM Qty: 112 Refill: _____

☐ 600 mg q AM and 400 mg q PM Qty: 140 Refill: _____

☐ 600 mg q AM and 600 mg q PM Qty: 168 Refill: _____

☐ 600 mg q AM and 800 mg q PM Qty: 196 Refill: _____

Protease Inhibitor

SOVALDI (Sofosbuvir) 400mg

☐ 400mg (1 tablet) once daily

Quantity: 28 tablets (28 days) Refill #: _____

OLYSIO (Simeprevir) 150mg

☐ 150mg (1 capsule) once daily with food (not low fat) for 12 weeks

Quantity: 28 tablets (28 days) Refill #: 2

VIEKIRA PAK

☐ Take 2 tablets (ombitasvir/paritaprevir/ritonavir) once daily in the morning and 1 tablet (dasabuvir) twice daily in the morning and evening with a meal as directed by the Pak

Quantity: 28 days Refill #: _____

Polymerase Inhibitor

HARVONI (Ledipasvir/Sofosbuvir)

☐ 90mg/400mg (1 tablet) once daily

Quantity: 28 tablets (28 days)

Refill #: _____

Supportive Therapies

can provide supportive therapy, such as:

- Procrit
- Neupogen
- Epogen
- Neulasta
- Aranesp
- Promacta

Please provide an attached Rx if supportive therapy is needed.

INJECTION TRAINING

☐ will coordinate training ☐ Physician Office to coordinate training

RN/LPN to teach administration of injectable to caregiver/patient (in accordance with state laws)

LAB COORDINATION

☐ to Coordinate (please fill out lab request form)

Prescriber Information

Anticipated Start Date: _____ Physician Specialty: _____ Ship to: ☐ Patient ☐ Physician/Clinic

☐ Other: _____

Physician: _____

Phone #: _____ Fax #: _____ NPI #: _____ Contact Name: _____

Office Address: _____ City: _____ State: _____ Zip: _____

I authorize and its representatives to act as an agent to initiate and execute the insurance prior authorization process, coordinate and receive lab values, and arrange injection training.

Physician's Signature: _____ Date: _____