PREMIER PHARMACY SERVICES

Phone: 800-540-4700
Fax: 800-540-3400

To prescribe, send prescription to:
Premier Pharmacy Services
410 Cloverleaf Drive
Baldwin Park, CA 91706

HEPATITIS C ENROLLMENT FORM

Ship to: ☐ Patient ☐ Physician All supplies, including syringes and needles, will be dispensed if needed.

Patient Information

DOB: _____ ☐ Male ☐ Female SSN # _____

Patient's First Name: _____ Patient's Last Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Best Phone #: _____ Alternate Phone # : _____

Height: _____ Weight: _____ Emergency Contact: _____

Insurance Information: Please fax a copy of insurance card (front + back)

Primary Insurance: _____ Phone: _____

Policy #: _____ Group #: _____

Medical Necessity

Primary Diagnosis: _____ Allergies: _____ RNA Test Date: _____

ICD-10: ☐ B18.2 Chronic viral Hepatitis C ☐ Other ICD-10: _____ Viral Load: _____

Genotype: ☐ 1A ☐ 1B ☐ 2 ☐ 3 ☐ 4 ☐ 6 ☐ Other: _____

Previous treated for HCV? ☐ Yes ☐ No If yes, was patient a: ☐ Non-Responder [OR] ☐ Responder/Relapser

Previous Treatment: _____ Treatment Duration: From _____ To _____

Cirrhosis: ☐ Compensated ☐ De-Compensated Biopsy: ☐ Yes ☐ No Fibrosis Score _____ HIV co-infected: ☐ Yes ☐ No

Duration of therapy: ☐ 8 Weeks ☐ 12 Weeks ☐ 16 Weeks ☐ 24 Weeks

Prescriptions

☐ **HARVONI®** (ledipasvir and sofosbuvir)
Qty: 28-Day Supply
Ledipasvir 90 mg/sofosbuvir 400 mg, 1 tablet PO QD
Refill x: _____

☐ **VIEKIRA XR®** (ombitasvir, paritaprevir, ritonavir; dasabuvir)
Qty: 28-Day Supply
Dasabuvir 200 mg, Ombitasvir 8.33 mg, Paritaprevir 50 mg, Ritonavir 33.33 mg:
3 tablets PO QD w/ food
Refill x: _____

☐ **ZEPATIER™** (elbasvir and grazoprevir)
Qty: 28-Day Supply
Elbasvir 50 mg/grazoprevir 100 mg, 1 tablet PO QD
Refill x: _____

☐ **OLYSIO™** (simeprevir)
Qty: 28-Day Supply
150 mg capsule PO QD w/ food
Refill x: _____

☐ **SOVALDI®** (sofosbuvir)
Qty: 28-Day Supply
400 mg tablet PO QD
Refill x: _____

☐ **MAVYRET®** (glecaprevir,pibrentasvir)
Qty: 28-Day Supply
glecaprevir 100mg and pibrentasvir 40mg:
Take 3 tablets po QD with food
Refill x: _____

☐ **DAKLINZA®** (declatasvir)
Qty: 28-Day Supply
☐ 60mg 1 Tablet PO QD ☐ 30mg 1 Tablet PO QD ☐ 90mg PO QD
Refill x: _____

☐ **EPCLUSA®** (velpatasvir and sofosbuvir)
Qty: 28-Day Supply
Velpatasvir 100mg/Sofosbuvir 400mg, 1 Tablet PO QD
Refill x: _____

☐ **RIBAPAK™** (ribavirin)
☐ 400/400 28-day supply (400 mg AM & 400 mg PM)
☐ 600/400 28-day supply (600 mg AM & 400 mg PM)
☐ 600/600 28-day supply (600 mg AM & 600 mg PM)
Other day supply: _____ Refill x: _____
OPTIONAL DOSE REDUCTION:
☐ 200/400 28-day supply (200 mg AM & 400 mg PM)

☐ **VOSEVI®** (sofosbuvir 400 mg/velpatasvir 100 mg/voxilaprevir 100 mg)
Qty: 28-Day Supply
1 tablet PO QD w/ food
Refill x: _____

Prescriber Information

Physician Name (please print): _____ Contact Name: _____

NPI #: DEA#: Tax ID #:

Office Address: _____ City: _____ State: _____ ZIP: _____

Phone #: _____ Fax #: _____ Email: _____

I authorize this prescription and for Premier Specialty Pharmacy and it's representatives to act as an agent to execute and sign for the insurance prior authorization process

Physician Signature: _____ **Date:** _____