PREMIER
PHARMACY SERVICES

Fax: 800.540.3400
Phone: 800.540.4700

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

HEPATITIS C ORDER FORM

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

Patient Information

Patient First Name: _____ Patient Last Name: _____ DOB: _____

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

SSN: _____ Phone: _____ Alt Phone: _____

Emergency Contact Name: _____ Emergency Contact Number: _____

Allergies: _____

PLEASE ATTACH COPIES OF FRONT AND BACK OF PATIENT'S PRESCRIPTION INSURANCE CARDS AND MOST RECENT LABS

Clinical Information

Gender: ☐ Male ☐ Female Height: _____ Weight: _____

Diagnosis:
☐ B18.2 Chronic Viral Hepatitis C
☐ Other Diagnosis: ICD-10 Code _____ Description: _____
Date of Diagnosis: _____

Genotype: ☐ 1A ☐ 1B ☐ 2 ☐ 3 ☐ 4 ☐ 6 ☐ Other: _____ Viral Load: _____ RNA Test Date: _____

Cirrhosis: ☐ No ☐ Yes If yes, ☐ Compensated ☐ Decompensated Fibrosis Score: _____ HIV Co-infected?: ☐ No ☐ Yes

Previously Treated for HCV? ☐ No ☐ Yes If yes, was patient: ☐ Non-Responder ☐ Responder/Relapser

Previous Treatment: _____ From: _____ To: _____

Prescription

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

☐ **HARVONI**
☐ *Available generic: ledipasvir 90mg/sofosbuvir 400mg*
QTY: 28 Days
Directions: 1 TAB PO QD Refills: _____

☐ **EPCLUSA**
☐ *Available generic: velpatasvir 100mg/sofosbuvir 400mg*
QTY: 28 Days
Directions: 1 TAB PO QD Refills: _____

☐ **MAVYRET** *(glecaprevir 100mg/pibrentasvir 40mg)*
QTY: 28 Days
Directions: 3 TABS PO QD W/FOOD Refills: _____

☐ **VOSEVI** *(sofosbuvir 400mg/velpatasvir 100mg/voxilaprevir 100mg)*
QTY: 28 Days
Directions: 1 TAB PO QD W/FOOD Refills: _____

☐ **OTHER** Medication: _____

Directions: _____ QTY: _____ Refills: _____

Prescriber Information

PRIOR AUTHORIZATION

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____

Address: _____

City: _____ Zip: _____ Tel: _____ Fax: _____

Contact Person: _____

PRESCRIBER SIGNATURE
(Prescriber, please sign and date below)
No stamps. Signature and date must be completed in prescriber s handwriting.
NY prescriptions must be submitted via e script.

I authorize Premier Pharmacy and its representatives to act as an agent to initiate and execute prior authorization for the above patient in order to expedite the process, please provide chart notes and most recent labs.

Physician's Signature: _____ ☐ **Date:** _____/_____/_____
Sign here if substitution permissible

Physician's Signature: _____ ☐ **Date:** _____/_____/_____
Sign here if dispense as written and hand write below.

DAW ONLY: HAND WRITE "BRAND NECESSARY" IN THE BOX IN ORDER FOR BRAND NAME PRODUCT TO BE DISPENSED