Pharmacy Fax Number: _____
Faxed by: _____

HEPATOLOGY
Prescription Form

Prescription Authorization

Completed ☐

Today's Date _____ **Physician's Signature** _____ *(must be a wet signature)*

Physician Information

Completed ☐

First Name _____ Last Name_____ NPI#_____ DEA#_____ License#_____

Practice Name_____ Contact Person_____ Direct Line_____

Address_____ City_____ State_____ZIP_____Prescriber Specialty_____

Phone_____ Fax _____ Email _____

Patient Information

Completed ☐

First Name_____ Last Name_____ Male☐ Female☐ DOB_____ SSN _____

Address_____ City_____ State_____ Zip _____

Cell Ph _____ Home Ph _____ Work Ph _____

Email Address _____ Height _____ in Weight_____lbs

Prescription Information

For alternate directions, please cross out and write in*

Completed ☐

	Medication	Strength	Sig (Directions for Use)	Disp Qty	Refills
☐	**Daklinza** ® *(daclatasvir)*	☐ 30mg tab ☐ 60mg tab ☐ 90mg tab	Take 1 tablet by mouth once daily for _____weeks		
☐	**Epclusa** ® *(sofosbuvir/valpatasvir)*	400mg/100mg tab	Take 1 tablet by mouth once daily for _____weeks		
☐	**Harvoni** ® *(ledipasvir/ sofosbuvir)*	90mg/400mg tab	Take 1 tablet by mouth once daily for _____weeks		
☐	**Mavyret**® *(glecaprevir/pibrentasvir)*	100mg/40mg tab	Take 3 tablets by mouth once daily w/ food, for _____weeks		
☐	**Ribavirin**	200mg caps or tabs	Take 1 _____ (*tab/cap*) by mouth after morning meal once daily for _____weeks		
☐	**Sovaldi**® *(sofosbuvir)*	400mg tab	Take 1 tablet by mouth once daily for _____ weeks		
☐	**Technivie**® *(ombitasvir/ paritaprevir/ritonavir)*	12.5mg/75mg/50mg tab	Take 1 tablet by mouth with food in the morning, for _____weeks		
☐	**Viekira Pak**® *(ombitasvir/ paritaprevir/ritonavir & dasabuvir)*	12.5mg/75mg/50mg & 250mg tablets	With food: Take 2 pink and 1 of the beige tablets PO every morning, then take the 2nd beige tablet PO in the evening		
☐	**Viread**® *(tenofovir disoproxil fumarate)*	☐ 150mg tab ☐ 250mg tab ☐ 200mg tab ☐ 300mg tab	Take 1 tablet by mouth once daily for _____weeks		
☐	**Zepatier** ®	50mg/100mg tablet	Take 1 tablet by mouth once daily for _____weeks		
☐	**Other Rx:**				

Diagnosis / Clinical Information *(provide copies of patient clinicals and labs to expedite a Prior Authorization Process)*

Completed ☐

HCV-RNA _____IU/mL Genotype_____

ICD-10 Code (Diagnoses) _____ _____ _____ _____

Step Therapy *(Patient tried & failed any previous medications?)*

If so, which ones and when?_____

Drug Sensitivities _____

Current Medications_____

Current OTC/Vitamins_____

Cirrhosis? (Y/N) _____ If yes, are they:

☐Compensated or ☐Decompensated?

Pregnant? (Y/N) _____ Alcohol Use? (Y/N) _____

Tobacco Use? (Y/N) _____

Recent Hosp Stay/Surgery?(Y/N) _____

If yes, provide details _____

_____

Insurance Information

Insurance:_____

ID:_____

BIN:_____

PCN:_____

Group: _____