Hepatitis C

accredo®

PRESCRIPTION & ENROLLMENT FORM

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient's name _____

Date of birth _____ ❑ Male ❑ Female Last 4 digits of SSN _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Parent/guardian (if applicable) _____

Home phone _____ Work phone _____ Cell phone _____

Evening phone _____ E-mail address _____

Patient's primary language: ❑ English ❑ Other If other, please specify _____

Please attach front and back of patient's insurance cards or complete information below.

Insurance company _____ Phone _____

Insured's name _____

Insured's employer _____ Relationship to patient _____

Identification # _____ Policy/group # _____

Prescription card: ❑ Yes ❑ No If yes, carrier _____

Policy # _____ Group # _____ Is patient eligible for Medicare? ❑ Yes ❑ No

Does patient have a secondary insurance? ❑ Yes ❑ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____

Prescriber's name and title _____

Office contact and title _____

Clinic/hospital affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____

NPI # _____ License # _____ MD specialty _____

❑ Send all shipments to MD office ❑ Send first fill to MD office

3 CLINICAL INFORMATION

Primary ICD-10 code _____

Comorbidities _____

❑ NKDA ❑ Known drug allergies _____

Current weight _____ kg/lbs Date recorded _____ Cirrhosis ❑ Yes ❑ No

HCV genotype: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ Subtype _____

What is the pre-treatment (baseline) HCV RNA level (viral load)? _____ IU/mL

Collection date _____

Has the patient been previously treated for hepatitis C? ❑ Yes ❑ No, naïve to treatment

If yes, name the product(s) and date range(s) of treatment and outcome (if applicable)

_____

Responder status: ❑ Partial responder ❑ Null responder ❑ Relapser

Concurrent meds _____

4 PRESCRIBING INFORMATION

Medication	Strength / Formulation	Directions	Quantity/Refills
❑ Daklinza™ (daclatasvir)	❑ 60 mg tablet ❑ 30 mg tablet	❑ Take 1 tablet by mouth daily with Sovaldi (sofosbuvir) for 12 weeks with or without food. ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Epclusa® (sofosbuvir/ velpatasvir)	400 mg sofosbuvir/100 mg velpatasvir tablet	Take one tablet daily with or without food. Duration: ❑ 12 weeks ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Harvoni® (ledipasvir/ sofosbuvir)	90 mg ledipasvir/400 mg sofosbuvir tablet	Take one tablet daily. Duration: ❑ 8 weeks ❑ 12 weeks ❑ 24 weeks ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Mavyret™ (glecaprevir/pibrentasvir)	100 mg glecaprevir/40 mg pibrentasvir tablet	Take 3 tablets once daily at same time with food. Duration: ❑ 8 weeks ❑ 12 weeks ❑ 16 weeks	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Olysio® (simeprevir)	150 mg capsule	Take one (150 mg) capsule once daily with food.	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Ribavirin	❑ 200 mg tablet ❑ 200 mg capsule	Take _____ tabs/caps QAM and _____ tabs/caps QPM with food. ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Sovaldi® (sofosbuvir)	400 mg tablet	Take one (400 mg) tablet once daily. Duration: ❑ 12 weeks ❑ 24 weeks ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Technivie® (ombitasvir, paritaprevir, ritonavir)	Pak contains: tablet 12.5 mg ombitasvir/75 mg paritaprevir/ 50 mg ritonavir	❑ Take 2 tablets every morning with food daily for 12 weeks. ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Viekira XR® (dasabuvir, ombitasvir, paritaprevir and ritonavir tablets)	Pack contains: tablet 200 mg dasabuvir/8.33 mg ombitasvir/ 50 mg paritaprevir/33.33 mg ritonavir	Take 3 tablets at the same time once daily with meal. Swallow whole. Duration: ❑ 12 weeks ❑ 24 weeks ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Vosevi™ (sofosbuvir/velpatasvir/ voxilaprevir)	400 mg sofosbuvir/100 mg velpatasvir/ 100 mg voxilaprevir tablet	Take one tablet daily with food. Select previous treatment experience if applicable: ❑ Previous use of NS5A ❑ Previous use of sofosbuvir without NS5A	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Zepatier™ (elbasvir/ grazoprevir)	50 mg elbasvir/100 mg grazoprevir tablet NS5A resistant polymorphisms: ❑ Yes ❑ No	❑ Take one tablet daily with or without food. ❑ Other _____ Duration: ❑ 12 weeks ❑ 24 weeks ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Other medication			❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Prescriber please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer the therapy		As needed for administration	Send quantity sufficient for medication days supply

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary. I authorize HUB to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan.

Prescriber's signature (sign below) **(Physician attests this is his/her legal signature. NO STAMPS)**

PHYSICIAN SIGNATURE REQUIRED

Date _____ Substitution allowed _____ Date _____ Dispense as written _____

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Please fax completed form to the Hep C team at 888.302.1028.

To reach your team, call toll-free 888.608.9010.

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