Prescription & Enrollment Form

Hepatitis C

accredo®

677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient's first name _____
Last name _____ Middle initial _____
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 copies of 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 first name _____ Last name _____
Prescriber's title _____
If NP or PA, under direction of Dr. _____
Office contact and title _____
Office contact e-mail _____
Office/clinic/institution name _____
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
❑ Epclusa® (sofosbuvir/ velpatasvir)	400mg sofosbuvir/100mg 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)	90mg ledipasvir/400mg 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)	100mg glecaprevir/40mg 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 _____
❑ Ribavirin	❑ 200mg tablet ❑ 200mg capsule	Take _____ tabs/caps QAM and _____ tabs/caps QPM with food. ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Sovaldi® (sofosbuvir)	400mg tablet	Take one (400mg) tablet once daily. Duration: ❑ 12 weeks ❑ 24 weeks ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Viekira Pak® (ombitasvir, paritaprevir and ritonavir tablets; dasabuvir tablets)	Pak contains: ombitasvir, paritaprevir, ritonavir (pink tablets): 12.5/75/50mg dasabuvir (beige tablets): 250mg	❑ Take two ombitasvir, paritaprevir, ritonavir (pink) tablets once daily AM and one dasabuvir (beige) tablet twice daily AM and PM with a meal. ❑ Other _____ Duration: ❑ 12 weeks ❑ 24 weeks ❑ Other _____	❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Vosevi™ (sofosbuvir/velpatasvir/ voxilaprevir)	400mg sofosbuvir/100mg velpatasvir/ 100mg 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)	50mg elbasvir/100mg 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 also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

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

Date _____ Dispense as written _____ Date _____ Substitution allowed _____

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 808.650.6487. To reach your team, call toll-free 808.650.6488.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

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