Please fax both pages of completed form to your Hep C team at 888.302.1028.

To reach your team, call toll-free 888.608.9010.

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

Prescription & Enrollment Form

Hepatitis C

accredo®

Four simple steps to submit your referral.

1 Patient Information

Please attach copies of front and back of the patient's medical and prescription insurance cards.

❑ New patient ❑ Current patient

Patient's first name _____ Last name _____ Middle initial _____

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

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail address _____

❑ OK to leave message with alternate caregiver/contact Patient's primary language: ❑ English ❑ Other If other, please specify _____

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office address _____

Office contact and title _____

Office contact phone number _____ Office contact e-mail _____

Office/Infusion clinic name _____ Office/Infusion clinic affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____

NPI # _____ License # _____

❑ **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 _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

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			❑ 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

I hereby authorize Accredo to contact my prescribing provider to coordinate the delivery, receipt and storage of my prescription medication for the sole purpose of administration by my prescribing provider at my next scheduled appointment. Signature serves as the Patient Ship Authorization.

_____
Patient authorization

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

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

SIGN HERE

_____ **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.

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