WVUMedicine

Specialty Pharmacy

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To ePrescribe send prescription to:

WVU Medicine Specialty Pharmacy
3040 University Ave, STE 1400
Morgantown, WV 26505

HEPATITIS C ENROLLMENT FORM

TODAY'S DATE: _____

Patient Name: _____ _____
DOB:_____ Last Four of SSN:_____ Gender:_____
Weight:_____ Height:_____ Phone:_____
Address:_____ _____
City, State, Zip:_____ _____
Language Preference: ☐ English ☐ Spanish
☐ Other: ___ _____ ___ _____

Prescriber's Name:_____ _____
DEA:_____ _NPI:_____
Group/Hospital:_____ _____
Address:_____ _____ _____
City, State, Zip:_____ _____ _____
Phone:_____ Fax:_____
Contact Person:_____ _____ Phone:_____

Insurance Information: Please fax a copy of Insurance Card (Front + Back)

Medical Information (Please attach clinical notes for the Prior Authorization process)

☐ B18.2 Chronic Hepatitis C ☐ K72.90 Hepatic failure, unspecified without coma ☐ C22.0 Liver Cell Carcinoma
☐ Other Diagnosis: ICD-10 Code:_____ Description:_____

Genotype:_____ HIV Coinfected: ☐ Yes ☐ No HBV Coinfected: ☐ Yes ☐ No
1st Viral Load:_____IU/ml 1st Viral Load Date:_____ 2nd Viral Load:_____IU/ml 2nd Viral Load Date:_____
Previous Therapy History: ☐ Naïve ☐ Relapsed ☐ Partial Responder ☐ Null
Dates of previous therapy and meds:_____
Cirrhosis ☐ Yes ☐ No Compensated Liver Disease: ☐ Yes ☐ No Fibrosis Score:_____
Liver Transplant: ☐ Yes ☐ No Waiting for Liver Transplant: ☐ Yes ☐ No

*****Please include hard copies of: Genotype, 1st AND 2nd Viral Load (6 months apart), EGFR, Fibrosure/Elastography, Hep A/B vaccine history/labs, CBC, CMP, HIV, PT/INR, H&P. NS5A Resistance Testing, and pertinent office visit notes.*****

Prescription Information

Medication	Directions	Duration of Therapy	Quantity	Refills
☐ Epclusa (velpatasvir, sofobuvir) 100mg / 400mg tablet	Take one tablet daily	_____ Weeks	28 Days (28 Tablets)	Refills:___
☐ Harvoni (ledipasvir, sofosbuvir) 90mg / 400mg tablet	Take one tablet daily	_____ Weeks	28 Days (28 Tablets)	Refills:___
☐ Mavyret (glecaprevir, pibrentasvir) 100mg / 40mg tablet	Take three tablets daily with food	_____ Weeks	28 Days (84 Tablets)	Refills:___
☐ Ribavirin ☐ 200mg tablet ☐ 200mg capsule	Take daily with food ___ ___ mg AM + ____ mg PM	_____ Weeks	28 Days (28 Tablets)	Refills:___
☐ Viekira Pak (dasabuvir, ombitasvir, paritaprevir, ritonavir) 12.5mg/75mg/50mg	Take two pink tablets AM daily and one beige tablet twice daily	_____ Weeks	28 Days (84 Tablets)	Refills:___
☐ Vosevi (sofobuvir, velpatasvir, voxilaprevir) 400mg / 100mg / 100mg tablet	Take one tablet daily with food	_____ Weeks	28 Days (28 Tablets)	Refills:___
☐ Zepatier (elbasvir, grazoprevir) 50mg / 100mg	Take one tablet daily	_____ Weeks	28 Days (28 Tablets)	Refills:___
☐ Other:_____		_____ Weeks	__ Days (__ Tablets)	Refills:___

*****Please include clinical notes and hard copies of: Genotype, 1st AND 2nd Viral Load (6 months apart), EGFR, Fibrosure/Elastography, Hep A/B vaccine history/labs, CBC, CMP, HIV, PT/INR, H&P, NS5A Resistance Testing, and pertinent office visit notes with enrollment forms.*****

In order for a brand name to be dispensed, the prescriber must hand write "Brand Medically Necessary" or "Brand Necessary" on the following line: _____ _____

Prescriber Signature:_____ **Date:**_____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize Allied Health Solutions Specialty Pharmacy and/or its affiliates to complete and submit prior authorization (PA) requests to payers for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.