

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: Naive 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
<input type="checkbox"/> Epclusa (velpatasvir, sofosbuvir) 100mg / 400mg tablet	Take one tablet daily	_____ Weeks	28 Days (28 Tablets)	Refills: _____
<input type="checkbox"/> Harvoni (ledipasvir, sofosbuvir) 90mg / 400mg tablet	Take one tablet daily	_____ Weeks	28 Days (28 Tablets)	Refills: _____
<input type="checkbox"/> Mavyret (glecaprevir, pibrebtasvir) 100mg / 40mg tablet	Take three tablets daily with food	_____ Weeks	28 Days (84 Tablets)	Refills: _____
<input type="checkbox"/> Ribavirin <input type="checkbox"/> 200mg tablet <input type="checkbox"/> 200mg capsule	Take daily with food _____ mg AM + _____ mg PM	_____ Weeks	28 Days (28 Tablets)	Refills: _____
<input type="checkbox"/> 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: _____
<input type="checkbox"/> Vosevi (sofosbuvir, velpatasvir, voxilaprevir) 400mg / 100mg / 100mg tablet	Take one tablet daily with food	_____ Weeks	28 Days (28 Tablets)	Refills: _____
<input type="checkbox"/> Zepatier (elbasvir, grazoprevir) 50mg / 100mg	Take one tablet daily	_____ Weeks	28 Days (28 Tablets)	Refills: _____
<input type="checkbox"/> 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.

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