Hepatitis C Virus

COREXA PHARMACY

Patient Information

Patient name: _____ DOB: _____
Sex: ☐ Female ☐ Male SSN: _____ Ethnicity: _____
Language: _____ Wt: _____ ☐ kg ☐ lbs Ht: _____ ☐ cm ☐ in
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____
Local pharmacy: _____ Phone: _____
Insurance plan: _____ Plan ID: _____
Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: _____
NPI: _____
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email: _____
If shipping to prescriber: ☐ First Fill ☐ Always ☐ Never

Clinical Information (Please fax pertinent clinical and lab information)

Diagnosis: ☐ B18.2 (Chronic Hepatitis C Virus) Diagnosis date: _____
Genotype: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 Subtype: ☐ A ☐ B ☐ A/B ☐ N/A
Baseline viral load: _____ Date: _____
Degree of fibrosis: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4 ☐ _____
Cirrhosis: ☐ None ☐ Compensated ☐ Decompensated (CTP: ☐ B ☐ C)
Co-infection(s): ☐ None ☐ HIV ☐ HBV

Transplant status: ☐ N/A ☐ Pre-transplant ☐ Post-transplant
sCr: _____ GFR: _____ Date: _____
CKD stage: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ N/A Dialysis: ☐ Yes ☐ No
IL28B polymorphism: ☐ CC ☐ CT ☐ TT
Q80K polymorphism: ☐ Yes ☐ No NS5A polymorphism: ☐ Yes ☐ No
NS5A polymorphism type: ☐ M28 ☐ Q30 ☐ L31 ☐ Y93 ☐ _____

Prior Regimen ☐ Naïve ☐ Experienced (List below)	Start Date	End Date	Treatment Weeks	Response*
				☐ IC ☐ NR ☐ PR ☐ RLP
				☐ IC ☐ NR ☐ PR ☐ RLP
				☐ IC ☐ NR ☐ PR ☐ RLP

Response definitions: IC – Incomplete treatment, NR – Null Responder, PR – Partial Response, RLP - Relapser

Comorbidities: _____
Concomitant Medications: _____
Allergies: ☐ NKDA ☐ Other: _____

Prescription		Quantity	Duration	Refill
☐ **Daklinza®** (daclatasvir)	☐ Take 30 mg by mouth once daily ☐ Take 60 mg by mouth once daily ☐ Take 90 mg by mouth once daily	☐ 28 x 30 mg tablets ☐ 28 x 60 mg tablets ☐ 28 x 90 mg tablets	☐ 12 weeks ☐ 24 weeks	_____
☐ **Epclusa®** (velpatasvir/sofosbuvir)	☐ Take 100 mg/400 mg by mouth once daily	☐ 28 x 100 mg/400 mg tablets	☐ 12 weeks ☐ 24 weeks	_____
☐ **Harvoni®** (ledipasvir/sofosbuvir)	☐ Take 90 mg/400 mg by mouth once daily	☐ 28 x 90 mg/400 mg tablets	☐ 8 weeks ☐ 12 weeks ☐ 24 weeks	_____
☐ **Olysio®** (simeprevir)	☐ Take 150 mg by mouth once daily	☐ 28 x 150 mg capsules	☐ 12 weeks ☐ 24 weeks	_____
☐ **Sovaldi®** (sofosbuvir)	☐ Take 400 mg by mouth once daily	☐ 28 x 400 mg tablets	☐ 12 weeks ☐ 24 weeks	_____
☐ **Technivie™** (ombitasvir/paritaprevir/ritonavir)	☐ Take 2 tablets by mouth in the morning with food	☐ 56 x 12.5 mg/75 mg/50 mg tablets	☐ 12 weeks ☐ 24 weeks	_____
☐ **Viekira Pak®** (dasabuvir/ombitasvir/paritaprevir/ritonavir)	☐ Take 3 tablets by mouth in the morning and 1 tablet by mouth in the evening with food	☐ 112 x 250 mg/12.5 mg/75 mg/50 mg tablets	☐ 12 weeks ☐ 24 weeks	_____
☐ **Viekira XR™** (dasabuvir/ombitasvir/paritaprevir/ritonavir)	☐ Take 3 tablets by mouth once daily with food	☐ 84 x 200 mg/8.33 mg/50 mg/ 33.33 mg tablets		
☐ **Zepatier™** (elbasvir/grazoprevir)	☐ Take 50 mg/100 mg by mouth once daily	☐ 28 x 50/100 mg tablets	☐ 12 weeks ☐ 16 weeks	_____
☐ **Pegasys®** (peginterferon alfa-2a)	☐ Inject 180 mcg subcut once weekly ☐ _____	☐ 4 x 180 mcg	☐ PFS ☐ Autoinjector	_____
☐ **Ribasphere® Ribapak® Dose Pak** (ribavirin) ☐ **Moderiba™ Dose Pack** (ribavirin)	☐ Take _____ mg tablet by mouth every morning, _____ mg tablet by mouth every evening (_____ mg/day)	☐ 28 x 200 mg; 28 x 400 mg ☐ 28 x 400 mg; 28 x 400 mg ☐ 28 x 400 mg; 28 x 600 mg ☐ 28 x 600 mg; 28 x 600 mg	Tablets	_____
☐ **Ribasphere®**** (ribavirin)	☐ Take _____ mg tablet by mouth every morning, _____ mg tablet by mouth every evening (_____ mg/day)	☐ ____ x 200 mg	☐ Tablets ☐ Capsules	_____

***For the form (tablets or capsules), unless otherwise specified, pharmacy preference/availiability (or insurance preference) will be dispensed.*

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Prescriber's Signature: _____ Date: _____

I authorize Corexa Health Pharmacy and it's representatives to act as an agent to initiate and execute the insurance prior authorization and appeal process for this prescriptions and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice Corexa Pharmacy.