



HEPATITIS C - ENROLLMENT

Fax To: 817-332-5363

PHARMACY LOCATION
Phone: 817-335-5712
Fax: 817-332-5363
800 8th Avenue, Suite 130
Fort Worth, TX 76104

DATE: _____ SHIP TO:
DATE NEEDED: _____ PATIENT OFFICE

PATIENT INFO

NAME _____ E-MAIL _____ DOB _____ MALE FEMALE
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME TELEPHONE _____ MOBILE PHONE _____ SS# _____

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK) PRESCRIPTION INFORMATION

DIAGNOSIS CODE (ICD-10)

Date of Diagnosis _____
 B18.2 Chronic Hepatitis C Virus (HCV)
 Other _____

CLINICAL INFORMATION

Weight _____ kg/lb
Height _____ cm/in
Allergies _____ NKDA
Genotype: 1 2 3 4 5 6
Subtype: a b a/b NA
Cirrhosis: Y N
If Y: Compensated Decompensated
Liver Fibrosis: F0 F1 F2 F3 F4
Post Liver Transplant: Y N
 Baseline HCV RNA _____ IU/ml
Date of Lab _____
Co-Infection status: HIV HBV N/A
Treatment Naïve: Y N
If No:
Prior HCV Treatment:
Dates: _____ Drug Name _____
Duration of Treatment _____
 Incomplete Partial
 Non-Response Relapse
Dates: _____ Drug Name _____
Duration of Treatment _____
 Incomplete Partial
 Non-Response Relapse
Expected Duration of Therapy
 8 Weeks 12 Weeks
 16 Weeks 24 Weeks

EPLUSA® (sofosbuvir and velpatasvir)

EPLUSA®
400mg / 100mg Tablet
Directions:
 Take 1 tablet PO QD with or without food
Qty: 28 Refills: _____

EPLUSA® PEDIATRIC

EPLUSA® 200mg / 50mg Tablet
Directions:
 Take 1 tablet PO QD with or without food
Qty: 28 Refills: _____

Sofosbuvir and Velpatasvir

Sofosbuvir and Velpatasvir
400mg / 100mg Tablet
Directions:
 Take 1 tablet PO QD with or without food
Qty: 28 Refills: _____

HARVONI® (ledipasvir and sofosbuvir)

HARVONI®
90/400mg Tablet
Directions:
 Take 1 tablet PO QD with or without food
Qty: 28 Refills: _____

HARVONI® PEDIATRIC

HARVONI® 90/400 mg Tablet
 45/200 mg Pellet 33.75/150mg Pellet
Directions:
 Take 1 tablet PO QD with or without food
 Take the contents of 1 packet PO QD with or without food
Qty: 28 Tablets 28 Pellet Packets
Refills: _____

Ledipasvir and Sofobuvir

Ledipasvir and Sofobuvir
90/400mg Tablet
Directions:
 Take 1 tablet PO QD with or without food
Qty: 28 Refills: _____

MAVYRET™

MAVYRET™ 100mg/40mg Tablet
Directions: Take 3 tablets PO QD with food.
Qty: 84 Tablets Refills: _____

MAVYRET™ PEDIATRIC

MAVYRET™
 100/40 mg Tablet 50/20 mg Pellet
Directions: Take 3 tablets PO QD with food
 Take the contents of _____ packets PO QD with food
Qty: 1 month supply Refills: _____

VOSEVI™

VOSEVI™
400mg / 100mg / 100mg Tablet
Directions:
 Take 1 tablet PO QD with food
Qty: 28 Refills: _____

ZEPATIER™

ZEPATIER™ 50/100 mg Tablet
Directions:
 Take 1 tablet PO QD with or without food
Qty: 28 Refills: _____
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RIBAVIRIN

RIBAVIRIN:
 200mg Capsule 200mg Tablet
Directions:
 Take _____ tabs/caps PO q am and _____ tabs/caps q pm for a total of _____ mg daily with food.
Qty: _____ Tablets / Capsules
Refills: _____

XIFAXAN®

XIFAXAN®: 550mg
Directions: Take 1 Tab PO BID
Qty: 60 Refills: _____

OTHER

Directions: _____
Qty: _____ Refills: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____ Contact Person: _____
Telephone: _____ Fax: _____ Email: _____
Office Address: _____ City: _____ State: _____ Zip: _____
NPI #: _____ DEA #: _____ TAX ID #: _____ Medicaid Provider #: _____

PRESCRIBER'S SIGNATURE _____ (DATE) _____ *IF BRAND DRUGS ARE PREFERRED, HANDWRITE "BRAND MEDICALLY NECESSARY" ABOVE
I authorize the Pharmacy noted above and its representatives to act as an agent to initiate and execute the insurance prior authorization process. ©Encore, LP All rights Reserved

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