

Customer Information	Clinical Information and Prescription
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Customer Name: _____
 Date of Birth: _____ Sex: _____ SS# _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____
 Cell Phone: _____ E-mail: _____
Please attach copy of front and back of customer's prescription insurance card(s) if applicable
 Insurance Company Name: _____
 Insurance Company Phone: _____
 Policy holder: _____
 Policy holder Employer: _____
 Relationship to Customer: _____
 ID# _____ Group# _____
 RxBIN: _____ RxPCN: _____

Diagnosis: B18.2 Chronic Viral Hepatitis C Description: _____
 Co-infection: HIV HBV Patient's Weight: _____kg Hgb: _____g/dL (RBV only)
 Genotype: 1a 1b 2 3 4 5/6 HCV RNA level: _____IU/ml Date: ___/___/___
 Metavir Score: _____ Cirrhosis Yes No If yes, Compensated or Decompensated.
 Child-Pugh score: _____ Post liver transplant: Yes No Renal impairment: Yes No
 Previously treated for HCV? Yes No Prior treatment(s): _____
 Treatment response: Partial Null Intolerant (specify): _____
 Concurrent medications: _____
 Patients Allergies: _____
 Expected First Dose Date: ___/___/___ **Medical History -Please attach all lab/test results**

- Epclusa®** (400mg/100mg sofosbuvir/velpatasvir).
Take 1 tablet by mouth once daily with or without food for _____ weeks.
- Harvoni®** (90mg/400mg ledipasvir/sofosbuvir).
Take 1 tablet by mouth once daily with or without food for _____ weeks.
- Mavyret®** (100mg/40mg glecaprevir/pibrentasvir).
Take Three (3) tablets by mouth once daily with food for _____ weeks.
- Sovaldi®** (400mg sofosbuvir).
Take 1 tablet by mouth once daily for _____ weeks.
- Viekira Pak®** (250mg/12.5mg/75mg/50mg Dasabuvir/Ombitasvir/Paritaprevir/Ritonavir)
Take as directed on the Pak for 12 weeks.
- Vosevi®** (400mg/100mg/100mg sofosbuvir/velpatasvir/voxilaprevir)
Take 1 tablet by mouth once daily with or without food for 12 weeks.
- Zepatier™** (50mg/100mg elbasvir/grazprevir).
Take 1 tablet by mouth once daily for _____ weeks.

Ribavirin Rx:

Dispense: 28 day supply of medication with 0 1 2 Other: _____ Refills

Prescriber Signature: X _____ Date: ___/___/___

Prescriber Information

Practice/ Organization Name: _____
 Physician Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone#: _____ Fax#: _____
 DEA# _____ NPI# _____
 License#: _____ Medicaid UPIN#: _____
 Physician Specialty: _____
 Date Shipment Needed: _____
 Ship to: Patient Prescriber Other: _____
 Shipment Address: _____ Attn: _____
 City: _____ State: _____ Zip: _____
If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

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