ahma (rx)

HEPATITIS C

Toll free phone: 844.749.6628
Toll free fax: 855.516.3880

Patient Information – Please attach a copy of the patient's insurance card

Patient Name:		Date of Birth:	☐ Male ☐ Female
Address:	City:	State:	Zip:
Phone Number:	Alternate Phone Number:	Language:	
Allergies (Required): ☐ NKDA	Height:	Weight:	SSN:

Product Shipping Options: ☐ Patient's Home ☐ Prescriber O˜ice ☐ Alternative Address:

Prescriber Information

Practice Name:		O˜ice Contact:	
Prescriber :		NPI:	DEA:
Practice Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Clinical Information – *Please send all available chart notes including lab results*

ICD-10/ Diagnosis :		Patient type: ☐ naïve ☐ relapse ☐ partial responder ☐ null responder	
Co-Infections : ☐ None ☐ HIV ☐ Hepatitis B		Prior Failed Therapy:	
Is there cirrhosis? ☐ Yes ☐ No If yes, is it ☐ compensated ☐ decompensated	Fibrosis stage : ☐ F0 ☐ F0-F1 ☐ F1 ☐ F1-F2 ☐ F2 ☐ F2-F3 ☐ F3 ☐ F3-F4 ☐ F4 Activity: ☐ A1 ☐ A2 ☐ A3 ☐ A4	Child Pugh Score (if cirrhosis): ☐ A ☐ B ☐ C eGFR: _____ mL/min/1.73m^2	
Genotype/Subtype : ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Unknown For Olysio® order , is the Q80K polymorphism present? ☐ Yes ☐ No	Baseline viral load (IU/mL): Baseline viral load (Log UI/mL):	Is the patient interferon intolerant? ☐ Yes ☐ No	
Fibroscan™ (kPa):	FibroSURE®:	Is the patient awaiting liver transplant for hepatocellular carcinoma? ☐ Yes ☐ No	
NS5A Test results: ☐ resistant ☐ non-resistant	Hep B panel: ☐ HBsAg ☐ HBcAb ☐ HBsAb	* Please attach CBC and CMP lab values with prescription*	

Prescription Information

Medication	Dose	Directions	Quantity	Refills
☐ Mavyret™	100 mg / 40 mg	Take 3 tablets by mouth once daily with food for _____ weeks	84	
☐ Zepatier™	50 mg/100 mg	Take 1 tablet by mouth once daily with or without food for _____ weeks	28	
☐ Epclusa®	400 mg/100 mg	Take 1 tablet by mouth once daily with or without food for _____ weeks	28	
☐ Harvoni®	90 mg/400 mg	Take 1 tablet by mouth once daily with or without food for _____ weeks	28	
☐ Vosevi™	400/100/100mg	Take 1 tablet by mouth once daily with food for _____ weeks	28	
☐ Sovaldi®	400 mg	Take 1 tablet by mouth once daily with or without food for _____ weeks	28	
☐ Daklinza®	☐ 60 mg ☐ 30 mg*	Take 1 tablet by mouth once daily with or without food for _____ weeks *30 mg dose is utilized when given in combination with strong CYP3A inhibitors. 90 mg dose is to be administered when given in combination with moderate inducers of CYP3A.	28	
☐ Olysio®	150 mg	Take 1 capsule by mouth once daily with or without food for _____ weeks	28	
☐ Viekira™ XR (ombitasvir, paritaprevir, ritonavir, dasaburvir)	8.33/50/33.33/200 mg	Take 3 tablets by mouth once daily with food for _____ weeks	84	
☐ Ribavirin	200 mg ☐ Capsule ☐ Tablet	☐ Take 600 mg by mouth in the morning and 400 mg by mouth in the evening with food - (for patients ° 165 lbs) ☐ Take 600 mg by mouth in the morning and 600 mg by mouth in the evening with food - (for patients ¸ 165 lbs)	☐ 140 ☐ 168	

PRESCRIBER SIGNATURE (PLEASE SIGN AND DATE BELOW)

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, the receipt and submission of patient lab values and other patient data including pursuing available copay and financial assistance on behalf of my patients. If this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product substitution permitted ☐ Dispense as Written

Prescriber Signature: _____ _____
Date

urac ACCREDITED Specialty Pharmacy