HOME PARENTERAL SERVICES

Hepatitis C Virus

PHONE: 1-800-637-9201
FAX: 1-417-269-0692

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	_____
❑ **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	_____
❑ **Mavyret™** (glecaprevir + pibrentasvir)	Take 3 tablets by mouth once daily with food	84 x 100 mg/40 mg tablets	❑ 8 weeks ❑ 12 weeks ❑ 16 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®** (ombitasivir/paritaprevir/ritonavir)	Take 2 tablets by mouth in the morning with food	56 x 12.5mg/75mg/50mg tablets	12 weeks	_____
❑ **Vosevi™** (sofosbuvir/velpatasvir/voxilaprevir)	Take 1 tablet by mouth once daily with food	28 x 400 mg/100 mg/100mg tablets	12 weeks	_____
❑ **Zepatier™** (elbasvir/grazoprevir)	Take 1 tablet by mouth once daily	28 x 50/100 mg tablets	❑ 12 weeks ❑ 16 weeks	_____
❑ **Ribavirin**	Take _____ mg by mouth every morning, _____ mg 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.*

Stamp signature not allowed, physician signature required.

Prescriber's Signature: _____ _____ Date: _____
Substitution Permitted Dispense as Written

I authorize Home Parenteral Services and its representatives to act as an agent to initiate and execute the insurance prior authorization and appeal process for this prescription 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 to Home Parenteral Services.