

Patient Information	Prescriber + Shipping 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 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: <input type="checkbox"/> B18.2 (Chronic Hepatitis C Virus) Diagnosis date: _____ Genotype: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 Subtype: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> A/B <input type="checkbox"/> N/A Baseline viral load: _____ Date: _____ Degree of fibrosis: <input type="checkbox"/> F0 <input type="checkbox"/> F1 <input type="checkbox"/> F2 <input type="checkbox"/> F3 <input type="checkbox"/> F4 <input type="checkbox"/> _____ Cirrhosis: <input type="checkbox"/> None <input type="checkbox"/> Compensated <input type="checkbox"/> Decompensated (CTP: <input type="checkbox"/> B <input type="checkbox"/> C) Co-infection(s): <input type="checkbox"/> None <input type="checkbox"/> HIV <input type="checkbox"/> HBV		Transplant status: <input type="checkbox"/> N/A <input type="checkbox"/> Pre-transplant <input type="checkbox"/> Post-transplant sCr: _____ GFR: _____ Date: _____ CKD stage: 1 2 3 4 5 N/A Dialysis: Yes No IL28B polymorphism: CC CT TT Q80K polymorphism: <input type="checkbox"/> Yes <input type="checkbox"/> No NS5A polymorphism: <input type="checkbox"/> Yes <input type="checkbox"/> No NS5A polymorphism type: <input type="checkbox"/> M28 <input type="checkbox"/> Q30 <input type="checkbox"/> L31 <input type="checkbox"/> Y93 <input type="checkbox"/> _____		
Prior Regimen <input type="checkbox"/> Naive <input type="checkbox"/> Experienced (List below) _____ _____	Start Date _____ _____	End Date _____ _____	Treatment Weeks _____ _____	Response* <input type="checkbox"/> IC <input type="checkbox"/> NR <input type="checkbox"/> PR <input type="checkbox"/> RLP <input type="checkbox"/> IC <input type="checkbox"/> NR <input type="checkbox"/> PR <input type="checkbox"/> RLP <input type="checkbox"/> IC <input type="checkbox"/> NR <input type="checkbox"/> PR <input type="checkbox"/> RLP
*Response definitions: IC – Incomplete treatment, NR – Null Responder, PR – Partial Response, RLP - Relapser				
Comorbidities: _____ Concomitant Medications: _____ Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____				

Prescription	Quantity	Duration	Refill
<input type="checkbox"/> Daklinza® (daclatasvir)	<input type="checkbox"/> Take 30 mg by mouth once daily <input type="checkbox"/> Take 60 mg by mouth once daily <input type="checkbox"/> Take 90 mg by mouth once daily	28 x 30 mg tablets 28 x 60 mg tablets 28 x 90 mg tablets	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks _____
<input type="checkbox"/> Epclusa® (velpatasvir/sofosbuvir)	Take 100 mg/400 mg by mouth once daily	28 x 100 mg/400 mg tablets	12 weeks _____
<input type="checkbox"/> Harvoni® (ledipasvir/sofosbuvir)	Take 90 mg/400 mg by mouth once daily	28 x 90 mg/400 mg tablets	<input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks _____
<input type="checkbox"/> Mavyret™ (glecaprevir + pibrentasvir)	Take 3 tablets by mouth once daily with food	84 x 100 mg/40 mg tablets	<input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> 16 weeks _____
<input type="checkbox"/> Olysio® (simeprevir)	Take 150 mg by mouth once daily	28 x 150 mg capsules	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks _____
<input type="checkbox"/> Sovaldi® (sofosbuvir)	Take 400 mg by mouth once daily	28 x 400 mg tablets	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks _____
<input type="checkbox"/> Technivie® (ombitasivir/paritaprevir/ritonavir)	Take 2 tablets by mouth in the morning with food	56 x 12.5mg/75mg/50mg tablets	12 weeks _____
<input type="checkbox"/> Vosevi™ (sofosbuvir/velpatasvir/voxilaprevir)	Take 1 tablet by mouth once daily with food	28 x 400 mg/100 mg/100mg tablets	12 weeks _____
<input type="checkbox"/> Zepatier™ (elbasvir/grazoprevir)	Take 1 tablet by mouth once daily	28 x 50/100 mg tablets	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 16 weeks _____
<input type="checkbox"/> Ribavirin	Take _____ mg by mouth every morning, _____ mg by mouth every evening (_____ mg/day)	_____ x 200 mg	<input type="checkbox"/> Tablets <input type="checkbox"/> Capsules _____

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

Stamp signature not allowed, physician signature required.

Prescriber's Signature: _____ Date: _____

I authorize CoxHealth at Home 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 CoxHealth at Home.