DeliverIt Pharmacy Infusion & Specialty

Hepatology

Enrollment Form

Address: 12144 Dairy Ashford Rd. Suite 100,
T: 832.939.8137 Sugar and, TX 77478 F: 832.939.8128

PATIENT INFORMATION

Last Name ____ First Name ____

Social Security No ____ Date of Birth ____

Sex ☐ M ☐ F Weight_______ Height_______ Allergies__________

Home Phone ____ Work/Mobile ____

Home Address ____

City ____ State ____ Zip ____

PATIENT INSURANCE INFORMATION

Primary Medical Insurance ____ Medical Insurance Phone ____

Subscriber Name ____

Rx Card (PBM) ____ Group No ____

Prescription Card Bin # ____ PCN # ____

TREATMENT ARRANGEMENTS

•Start Date:_______________ Ship Meds ☐ Home ☐ Doctor's Office

Teaching by: ☐ Doctor's Office ☐ Other:_____________________

PRESCRIPTION INFORMATION

STATEMENT OF MEDICAL NECESSITY

Diagnosis:

☐ B18.2 Hepatitis C ☐ Other ICD 10 ____ ☐ Initial Therapy ☐ Previous Therapy **Genotype:** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 Other Subtype: ☐ a ☐ b

☐ HCV RNA Level ______________ ☐ Treatment Naïve ☐ Previous treatment ___________________ Date __________

Prior treatment (Duration): From _________ To __________ Total of _________ Weeks ☐ Co-infection ◯ HIV ◯ HBV

Cirrhosis: ☐ Compensated ☐ De-compensated ☐ Hepatocellular Carcinoma ☐ HIV Status ☐ Post-Liver Transplant

Fibroscan: ☐ Yes ☐ No Score:_______ **History of Liver biopsy?:** ☐ Yes ☐ No ☐ N/A **Fibrosis:** ☐ Yes ☐ No ☐ F1 ☐ F2 ☐ F3 ☐ F4

☐ **MAVYRET®** (Glecaprevir/Pibretasvir) 100/40mg	Take 3 tablets by mouth ONCE daily with meals.	28 Packs (84 Tablets)	________
☐ **VOSEVI®** (Sofosbuvir/Velpatasvir & Voxilaprevir)	Take 1 TABLET by mouth ONCE a day with meals.	28 Tablets	________
☐ **EPCLUSA®** (Sofosbuvir/Velpatasvir) 400/100mg	Take 1 TABLET by mouth ONCE a day with or without meals.	28 Tablets	________
☐ **HARVONI®** (Ledipasvir/Sofosbuvir) 90/400mg	Take 1 TABLET by mouth ONCE a day with or without meals.	28 Tablets	________
☐ **ZEPATIER®** (Elbasvir/Grazoprevir) 50/100mg	Take 1 TABLET by mouth ONCE a day with or without meals.	28 Tablets	________
☐ **DAKLINZA® 30mg** ☐ **DAKLINZA® 60mg** (Daclatasvir)	Take 1 TABLET by mouth ONCE a day with or without meals.	28 Tablets	________
☐ **VIEKIRA XR®** (Paritaprevir/Ombitasvir/Ritonavir & Dasabuvir)	Take 3 TABLETS by mouth once daily.	28 Packs (84 Tablets)	________
☐ **VIEKIRA PAK®** (Ombitasvir/Paritaprevir/Ritonavir & Dasabuvir)	Take TWO TABLETS of ombitasvir/paritaprevir/ritonavir and ONE TABLET of dasabuvir in the morning. Take ONE TABLET of dasabuvir in the evening.	4 Packs (112 Tablets)	________
☐ **SOVALDI®** (Sofosbuvir) 400mg	Take 1 TABLET by mouth ONCE a day with or without meals.	28 Tablets	________
☐ **TECHNIVIE®** (Ombitasvir/Paritaprevir/Ritonavir)	Take 2 tablets (One Pack) by mouth ONCE a day.	28 Packs (84 Tablets)	________
☐ **RIBAPAK®** ☐ **MODERIBA®** (Ribavirin)	☐ 600mg ☐ 800mg ☐ 1000mg ☐ 1200mg ☐ Take ______ mg in the morning _______ mg in the evening	28 days supply	________

HEPATITIS B TREATMENT

☐ **BARACLUDE** ☐ 0.5mg Tablet ☐ 1mg Tablet ☐ 0.05mg/mL Solution
Directions:______________________ Qty:________ Refill________

☐ **VIREAD** ☐ 150mg ☐ 200mg ☐ 300mg
Directions:______________________ Qty:________ Refill________

☐ **VEMLIDY** ☐ 25mg

Physician Signature: X______________________ ☐ **DAW (Dispense as Written)** **Date:** ____________

Physician Name: ____________ **Phone:** ____________ **Fax:** ____________ **Office Contact:** ____________

Physician Address: ____________ **NPI:** ____________ **DEA:** ____________