

Patient Information

Patient Name: _____ DOB: _____ Sex: Male Female SSN: _____ Wt (kg/lbs): _____ Ht (cm/in): _____
 Address: _____ Phone: _____ Alternate: _____
 Caregiver Name: _____ Relation to Patient: _____ Phone: _____
 Insurance Plan: _____ Plan ID: _____ BIN #: _____ PCN #: _____ GRP #: _____

Please fax a copy of the front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber Name: _____ DEA: _____ NPI: _____
 Address: _____
 Phone: _____ Alternate: _____ Fax: _____ Email: _____
 If shipping to prescriber: First Fill Always Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: B18.2 (Chronic Hepatitis C Virus) Diagnosis date: _____ Transplant status: N/A Pre-transplant Post-transplant
 Genotype: 1 2 3 4 5 6 Subtype: A B A/B N/A sCr: _____ GFR: _____ Date: _____
 Base viral load: _____ Date: _____ CKD stage: 1 2 3 4 5 N/A Dialysis: Yes No
 Degree of fibrosis: F0 F1 F3 F4 _____ IL28B polymorphism: CC CT TT
 Cirrhosis: None Compensated Decompensated (Child-Pugh Score: B C) Q80K polymorphism: Yes No NSSA polymorphism: Yes No
 Coinfection(s): None HIV HBV NSSA polymorphism type: M28 Q30 L31 Y93 Other: _____

Prior Regimen <input type="checkbox"/> Naive <input type="checkbox"/> Experienced (List below)	Start Date	End Date	Treatment Weeks	Response
_____	_____	_____	_____	<input type="checkbox"/> Incomplete treatment <input type="checkbox"/> Null Responder <input type="checkbox"/> Partial Response <input type="checkbox"/> Relapser
_____	_____	_____	_____	<input type="checkbox"/> Incomplete treatment <input type="checkbox"/> Null Responder <input type="checkbox"/> Partial Response <input type="checkbox"/> Relapser
_____	_____	_____	_____	<input type="checkbox"/> Incomplete treatment <input type="checkbox"/> Null Responder <input type="checkbox"/> Partial Response <input type="checkbox"/> Relapser

Comorbidities: _____
 Concomitant Medications: _____
 Allergies: NKDA Other: _____

Prescription

Directions, Quantity, Duration, Form

Refill

<input type="checkbox"/> Epclusa® (velpatasvir/sofosbuvir) 100mg/400mg tablet	Take 1 tablet by mouth once daily	<input type="checkbox"/> 12 weeks, #28 + 2 refills <input type="checkbox"/> 24 weeks, #28 + 5 refills
<input type="checkbox"/> Harvoni® (ledipasvir/sofosbuvir) 90mg/400mg tablet	Take 1 tablet by mouth once daily	<input type="checkbox"/> 8 weeks, #28 + 1 refill <input type="checkbox"/> 12 weeks, #28 + 2 refills <input type="checkbox"/> 24 weeks, #28 + 5 refills
<input type="checkbox"/> Mavyret® (glecaprevir/pibrentasvir) 100mg/40mg tablet	Take 3 tablets by mouth once daily with food	<input type="checkbox"/> 8 weeks, #84 + 1 refill <input type="checkbox"/> 12 weeks, #84 + 2 refills <input type="checkbox"/> 16 weeks, #84 + 3 refills
Ribavirin 200mg tab / cap <input type="checkbox"/> Tablets <input type="checkbox"/> Capsules Wt. less than 75kg -- 1000mg/day (5 tabs) Wt. 75kg or more -- 1200mg/day (6 tabs)	Take _____ tablet / capsule by mouth every morning Take _____ tablet / capsule by mouth every evening	# _____ for 28 day supply Refills: _____
<input type="checkbox"/> Vosevi® (sofosbuvir/velpatasvir/voxilaprevir) 400mg/100mg/100mg tablet	Take 1 tablet by mouth once a day	<input type="checkbox"/> 12 weeks, #28 + 2 refills
<input type="checkbox"/> Zepatier™ (elbasvir/grazoprevir) 50mg/100mg tablet	Take 1 tablet by mouth once daily	<input type="checkbox"/> 12 weeks, #28 + 2 refills <input type="checkbox"/> 16 weeks, #28 + 3 refills

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Prescriber's Signature: _____ Date: _____

I authorize AmeriPharma and its representatives to act as an agent to initiate and execute the insurance prior authorization 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 AmeriPharma.

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