

Hepatitis C Virus

Patient Information		Prescriber + Shipping Information			
Patient name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____ Ethnicity: _____ Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> 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: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> 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"/> Naïve <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
<i>*Response definitions: IC – Incomplete treatment, NR – Null Responder, PR – Partial Response, RLP - Relapser</i>					
Comorbidities: _____ Concomitant Medications: _____ Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____					
Expected Duration of Therapy: 8 weeks 12 weeks 16 weeks 24 weeks					
Prescription		Quantity		Refill	
<input type="checkbox"/> Epclusa® (velpatasvir/sofosbuvir)	<input type="checkbox"/> Take 100 mg/400 mg by mouth once daily	<input type="checkbox"/> 28 x 100 mg/400 mg tablets	_____		
<input type="checkbox"/> Harvoni® (ledipasvir/sofosbuvir)	<input type="checkbox"/> Take 90 mg/400 mg by mouth once daily	<input type="checkbox"/> 28 x 90 mg/400 mg tablets	_____		
Mavyret™ (glecaprevir + pibrentasvir)	Take 3 tablets by mouth once daily with food	84 x 100 mg/40 mg tablets	_____		
<input type="checkbox"/> Sovaldi® (sofosbuvir)	<input type="checkbox"/> Take 400 mg by mouth once daily	<input type="checkbox"/> 28 x 400 mg tablets	_____		
<input type="checkbox"/> Vosevi™ (sofosbuvir/velpatasvir/voxilaprevir)	<input type="checkbox"/> Take 1 tablet by mouth once daily with food	<input type="checkbox"/> 28 x 400 mg/100 mg/100 mg tablets	_____		
**For the form (tablets or capsules), unless otherwise specified, pharmacy preference/availability (or insurance preference) will be dispensed.					
Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____					
Prescriber's Signature: _____					Date: _____
I authorize Total Care Rx, Inc. 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 Total Care Rx, Inc.					

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