Hepatitis C

Rx International Pharmacy

Phone: (305) 221-1421
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Patient Information

Patient name: _____ DOB: _____
Sex: ❑ Female ❑ Male SS #: _____
Primary language: _____ Wt: _____ Ht: _____
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Primary phone: _____ Alternate phone: _____
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 address: _____
If shipping to prescriber: ❑ 1st Fill ❑ Always ❑ Never

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

Diagnosis ICD-10: ❑ B18.2 (Chronic Hepatitis C Virus) ❑ _____
Genotype: ❑ 1a ❑ 1b ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6
Treatment type: ❑ naïve ❑ Interferon-experienced ❑ DAA-experienced
Baseline viral load: _____ Date: _____
Degree of fibrosis: ❑ F0 ❑ F1 ❑ F2 ❑ F3 ❑ F4
Other fibrosis score: _____
Cirrhosis: ❑ none ❑ compensated ❑ decompensated

Co-infection(s): ❑ none ❑ HIV ❑ HBV
Child-Pugh class: ❑ A ❑ B ❑ C
Transplant status: ❑ N/A ❑ Pre-transplant ❑ Post-transplant
CKD stage: ❑ 1 ❑ 2 ❑3 ❑4 ❑5 ❑ N/A Dialysis: ❑ Yes ❑ No
IL28B: ❑ CC ❑ CT ❑ TT NS5A polymorphism: ❑ Yes ❑ No
NS5A polymorphism type: ❑ M28 ❑ Q30 ❑ L31 ❑ Y93 ❑ _____

Prior Therapy	Approximate Start Date	Approximate End Date	Treatment Weeks

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

Prescription

❑ **Daklinza®**	❑ Take 60 mg once daily by mouth ❑ Take 30 mg once daily by mouth Anticipated treatment duration: ❑ 12 weeks ❑ 24 weeks	Qty: 28 tablets Qty: ❑ 28 tablets ❑ _____	Refills: _____ Refills: _____
❑ **Harvoni®**	Take 90 mg/400 mg once daily by mouth Anticipated treatment duration: ❑ 8 weeks ❑ 12 weeks ❑ 24 weeks	Qty: 28 tablets	Refills: _____
❑ **Olysio®**	Take 150 mg once daily by mouth Anticipated treatment duration: ❑ 12 weeks ❑ 24 weeks	Qty: 28 capsules	Refills: _____
❑ **Sovaldi®**	Take 400 mg once daily by mouth Anticipated treatment duration: ❑ 12 weeks ❑ 24 weeks	Qty: 28 tablets	Refills: _____
❑ **Technivie™**	Take 2 tablets in the AM by mouth with food Anticipated treatment duration: ❑ 12 weeks	Qty: 56 tablets	Refills: _____
❑ **Viekira Pak™**	Take 3 tablets in the AM and 1 tablet in the PM with food Anticipated treatment duration: ❑ 12 weeks ❑ 24 weeks	Qty: 112 tablets	Refills: _____
❑ **Zepatier™**	Take 50 mg/100 mg once daily by mouth Anticipated treatment duration: ❑ 12 weeks ❑ 16 weeks	Qty: 28 tablets	Refills: _____

❑ **Pegasys PFS** 180 mcg SQ QWK (4 PFS) Other dose and Sig:_____ Refills: _____
❑ **Pegasys Proclick** 180 mcg/0.5mL SQ QWK (4 Autoinjector) Refills: _____

❑ **Ribasphere® Ribapak® Dose Pak OR ❑ Moderiba™ Dose Pack** Refills: _____
❑ 1000 mg/day 600 mg tablet QAM, 400 mg tablet QPM (56 tabs)
❑ 600 mg/day 200 mg tablet QAM, 400 mg tablet QPM (56 tabs)
❑ 1200 mg/day 600 mg tablet QAM, 600 mg tablet QPM (56 tabs)
❑ 800 mg/day 400 mg tablet QAM, 400 mg tablet QPM (56 tabs)

❑ **Ribasphere®** **OR** ❑ **Ribavirin** 200 mg Refills: _____
❑ 1000 mg/day Take 3 tabs/caps QAM, 2 tabs/caps QPM (140 tabs)
❑ 600 mg/day Take 1 tabs/caps QAM, 2 tabs/caps QPM (84 tabs)
❑ 1200 mg/day Take 3 tabs/caps QAM, 3 tabs/caps QPM (168 tabs)
❑ 800 mg/day Take 2 tabs/caps QAM, 2 tabs/caps QPM (112 tabs)

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

Prescriber's Signature:_____ Date: _____

I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.