

Ship to: Patient Office (first fill only) Other

Date: _____ Needs by Date: _____

PATIENT INFORMATION

Patient Name _____
 Address _____
 Address 2 _____
 City, State, ZIP _____
 Preferred Phone _____ Type _____
 Alternate Phone _____ Type _____
 Email _____
 Ethnicity _____
 DOB (mm/dd/yyyy) _____ Gender Male Female

PRESCRIBER INFORMATION

Prescriber Name _____ Specialty _____
 State License # _____ UPIN _____
 DEA _____ NPI _____
 Group/Hospital _____
 Address _____
 City, State, ZIP _____
 Phone _____ Fax _____
 Office Contact _____ Phone _____

INSURANCE INFORMATION (Please fax FRONT and BACK copy of all Insurance cards (Prescription and Medical))

CLINICAL INFORMATION

Diagnosis (Please include diagnosis name and ICD-10)
 Diagnosis: ICD-10 Code: B18.2 (Chronic HCV) Other: _____
Genotype: _____ Subtype: _____
 Viral Load: _____ Date: _____
 Weight: _____ lbs/kg Height: _____ in/cm
 Is the patient pregnant, nursing, or planning pregnancy?: Yes No N/A
 Degree of fibrosis: F0 F1 F2 F3 F4
 Cirrhosis: Compensated Decompensated None
 Co-infection(s): None HIV HBV
 Transplant Status: N/A Pre-Transplant Post-Transplant

Therapy: New Continuing Therapy Restart
 Lab Data: Include copy of last CBC including HgB, ALT and AST: _____
 Concomitant medications: _____
 Allergies: _____
 Previously treated for HCV?: Yes No Number of weeks: _____
 Results: Relapsed Partial Response Null Response Incomplete
 Prior failed medication (medication and duration of treatment/reason for d/c): _____
 IL28B: CC CT TT NS5A polymorphism: Yes No
 NS5A polymorphism type: M28 Q30 L31 Y93 _____
 Q80k polymorphism: Yes No

PRESCRIPTION INFORMATION

Medication	Directions	Duration	Qty	Refills
<input type="radio"/> Daklinza® (daclatasvir)	<input type="radio"/> Take 30mg by mouth once daily <input type="radio"/> Take 60mg by mouth once daily <input type="radio"/> Take 90mg by mouth once daily	<input type="radio"/> 12 weeks <input type="radio"/> 24 weeks	28	
<input type="radio"/> Epclusa® (velpatasvir/sofosbuvir)	<input type="radio"/> Take 1 tablet (100/400mg) by mouth once daily	<input type="radio"/> 12 weeks <input type="radio"/> 24 weeks	28	
<input type="radio"/> Harvoni™ (ledipasvir/sofosbuvir)	<input type="radio"/> Take 1 tablet (90/400mg) by mouth once daily	<input type="radio"/> 8 weeks <input type="radio"/> 12 weeks <input type="radio"/> 24 weeks	28	
<input type="radio"/> Mavyret™ (glecaprevir/pibrentasvir)	<input type="radio"/> Take 3 tablets (100/40mg) by mouth once daily with food	<input type="radio"/> 8 weeks <input type="radio"/> 12 weeks <input type="radio"/> 16 weeks	84	
<input type="radio"/> Olysio® (simeprevir)	<input type="radio"/> Take 1 tablet (100/40mg) by mouth once daily with food	<input type="radio"/> 12 weeks <input type="radio"/> 24 weeks	28	
<input type="radio"/> ribavirin	<input type="radio"/> Take 200mg by mouth in the morning and 400mg in the evening <input type="radio"/> Take 400mg by mouth in the morning and 400mg in the evening <input type="radio"/> Take 600mg by mouth in the morning and 400mg in the evening <input type="radio"/> Take 600mg by mouth in the morning and 600mg in the evening <input type="radio"/> Other: _____			
<input type="radio"/> RibaPak®				
<input type="radio"/> Moderiba™ Dose Pack				
<input type="radio"/> Sovaldi® (sofosbuvir)	<input type="radio"/> Take 1 tablet (400mg) by mouth once daily <input type="radio"/> Other: _____	<input type="radio"/> 12 weeks <input type="radio"/> 24 weeks	28	
<input type="radio"/> Technivie™ (ombitavir/paritaprevir/ritonavir)	<input type="radio"/> Take 2 tablets (12.5/75/50mg) by mouth with food in the morning	<input type="radio"/> 12 weeks	56	
<input type="radio"/> Viekira Pak™ (ombitavir/paritaprevir/ritonavir/dasabuvir)	<input type="radio"/> Take 2 pink tablets (12.5/75/50mg) by mouth once daily in the morning and 1 beige tablet (250mg) twice daily with food	<input type="radio"/> 12 weeks <input type="radio"/> 24 weeks	112	

PRESCRIPTION INFORMATION

Medication	Directions	Duration	Qty	Refills
<input type="radio"/> Vosevi™ (sofosbuvir/velpatasvir/voxilaprevir)	<input type="radio"/> Take 1 tablet (400/100/100 mg) by mouth once daily with food.	<input type="radio"/> 12 weeks	28	
<input type="radio"/> Zepatier™ (elbasvir/grazoprevir)	<input type="radio"/> Take 1 tablet (50/100mg) by mouth once daily	<input type="radio"/> 12 weeks <input type="radio"/> 16 weeks	28	

By signing below, I authorize Lumicera Health Services and its representatives to act as my agent for prior authorization and prescription processing for this patient.

Prescriber Signature: _____ *PRODUCT SUBSTITUTION PERMITTED*
_____ *Date*
_____ *DISPENSE AS WRITTEN*