Lumicera Health Services
2601 West Beltline Hwy, Ste 302, Madison, WI 53713 / Phone: (855) 847-3553 / Fax: (855) 847-3558
5350 East High Street, Ste 200, Phoenix, AZ 85054 / Phone: (855) 847-3553 / Fax: (855) 847-3558

Hepatitis C Enrollment Form

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

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PRESCRIPTION INFORMATION

Medication	Directions	Duration	Qty	Refills
○ Vosevi™ (sofosbuvir/ velpatasvir/voxilaprevir)	○ Take 1 tablet (400/100/100 mg) by mouth once daily with food.	○ 12 weeks	28	
○ Zepatier™ (elbasvir/grazoprevir)	○ Take 1 tablet (50/100mg) by mouth once daily	○ 12 weeks ○ 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*