Hepatitis C Enrollment Form
Medications A-L
(Epclusa, Harvoni, Ledipasvir/Sofosbuvir)

Fax Referral To: 1-888-280-1191 OR 787-759-4161
Phone: 1-888-280-1190 OR 787-759-4162
Email Referral To: Customer.ServiceFax@CVSHealth.com
Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ DOB: _____
Address: _____ City, State, ZIP Code: _____
Gender: ☐ Male ☐ Female
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____
Relationship to minor: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
NPI #: _____ DEA #: _____ Group or Hospital: _____
Address: _____ City, State, ZIP Code: _____
Phone: _____ Fax_____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

Diagnosis (ICD-10):

☐ B17.10 Acute Hepatitis C without hepatic coma
☐ B17.11 Acute Hepatitis C with hepatic coma
☐ B18.2 Chronic Hepatitis C
☐ B19.20 Unspecified Viral Hepatitis C without hepatic coma
☐ B20 HIV
☐ Other Code: _____ Description _____

Patient Clinical Information:

Allergies: _____ Weight: _____lb/kg Height: _____in/cm
HCV Genotype: ☐1a ☐1b ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 AND ☐ No Cirrhosis ☐ Compensated Cirrhosis ☐ Decompensated Cirrhosis
Is patient: ☐Naïve ☐Partial Responder ☐Non-Responder ☐Relapser; Last Date of Therapy: _____ Product Name(s): _____
Is patient currently on Hepatitis C Virus therapy? ☐No ☐Yes, Therapy Start Date: _____ Product Name(s): _____
Is patient post-liver transplant? ☐ Yes ☐ No For Zepatier genotype 1a patients, NS5A polymorphism present? ☐ Yes ☐ No

Nursing:

Specialty pharmacy to coordinate injection training/home health nurse visit as necessary? ☐ Yes ☐ No
Site of Care: ☐ MD office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Health
Injection training not necessary. Date training occurred: _____
Reason: ☐ MD office training patient ☐ Pt already independent ☐ Referred by MD to alternate trainer

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Epclusa (sofosbuvir / velpatasvir)	Fixed-dose combination tablet of 400 mg sofosbuvir / 100 mg velpatasvir	Take one tablet once daily.	Quantity: _____ Refills: _____
☐ Harvoni (ledipasvir/ sofosbuvir)	Fixed-dose combination tablet of 90 mg ledipasvir / 400 mg sofosbuvir	Take PO once daily with or without food. Do not take within 4 hours of antacids.	Quantity: 28-day supply Refills: ☐ 8 weeks ☐ 12 weeks ☐ 24 weeks
☐ Ledipasvir/ Sofosbuvir	Fixed-dose combination tablet of 90 mg ledipasvir / 400 mg sofosbuvir	Take PO once daily with or without food. Do not take within 4 hours of antacids.	Quantity: 28-day supply Refills: ☐ 8 weeks ☐ 12 weeks ☐ 24 weeks

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute
Prescriber's Signature: _____ **Date:** _____

May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's Signature: _____ **Date:** _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **ATTN: New York and Iowa providers,** please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

Medications M-S
Hepatitis C Enrollment Form

(Mavyret, Pegasys, Pegintron, Ribavirin, Ribasphere RibaPak , Sofosbuvir/Velpatasvir, Sovaldi)

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Mavyret Tablet (glecaprevir and pibrentasvir)	Fixed-dose combination tablet of 100 mg glecaprevir and 40 mg pibrentasvir	Take three tablets PO once a day with food.	Quantity: 28-day supply Refills: ☐ 8 weeks ☐ 12 weeks ☐ Other_____
☐ Mavyret Oral Pellet (glecaprevir and pibrentasvir)	Fixed-dose combination oral pellet of 50 mg glecaprevir and 20 mg pibrentasvir	_____kg/lb ☐ Take three packets of oral pellets PO once daily with food. ☐ Take four packets of oral pellets PO once daily with food. ☐ Take five packets of oral pellets PO once daily with food.	Quantity: 28-day supply Refills: ☐ 8 weeks ☐ 12 weeks ☐ Other_____
☐ Pegasys (peginterferon alfa-2a)	☐ 180 mcg / 0.5 mL ProClick Autoinjector ☐ Other: _____	☐ Inject 180 mcg SC once a week as directed. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Pegintron (peginterferon alfa-2b)	☐ 120 mcg REDIPEN ☐ 150 mcg REDIPEN ☐ Other: _____	☐ Inject _____ mcg SC weekly. ☐ Other: _____	Quantity: _____ Refills: _____
☐ Ribavirin	☐ 200 mg tablets ☐ 200 mg capsules	Take ____ tabs/caps PO q am and _____ tabs/caps q pm for a total of _____ mg daily with food.	Quantity: _____ Refills: _____
☐ Ribasphere RibaPak (ribavirin)	☐ 600 / 600 mg ☐ 600 / 400 mg ☐ 400 / 400 mg ☐ 200 / 400 mg	Take _____ mg PO q am and _____ mg q pm for a total of _____ mg daily with food.	Quantity: _____ Refills: _____
☐ Sofosbuvir/ Velpatasvir	Fixed-dose combination tablet of 400 mg sofosbuvir / 100 mg velpatasvir	Take one tablet once daily.	Quantity: _____ Refills: _____
☐ Sovaldi (sofosbuvir)	☐ 400 mg tablets	Take one 400 mg tablet PO once a day.	Quantity: 28-day supply Refills: _____

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Medications M-Z
Hepatitis C Enrollment Form
(Technivie, Viekira Pak, Vosevi, Zepatier)

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Technivie (ombitasvir/paritaprevir /ritonavir)	Fixed dose combination tablet of ombitasvir / paritaprevir / ritonavir 12.5 mg / 75 mg / 50 mg	Take two tablets once daily in the morning.	Quantity: 28-day supply Refills:12 weeks
☐ Viekira Pak (ombitasvir/paritaprevir /ritonavir tabs and dasabuvir tabs)	Copackaged ombitasvir / partiaprevir / ritonavir 12.5 mg / 75 mg / 50 mg and dasabuvir 250 mg	Take 2 pink tablets (ombitasvir, paritaprevir, ritonavir) once daily (morning) and 1 beige tablet (dasabuvir) twice daily (morning and evening) with meals.	Quantity: 28-day supply Refills: ☐ 12 weeks ☐ 24 weeks
☐ Vosevi (sofosbuvir, velpatasvir, and voxilaprevir)	Fixed-dose combination tablet of 400 mg sofosbuvir / 100 mg velpatasvir/100 mg voxilaprevir	Take one tablet PO once a day with food.	Quantity: 28-day supply Refills: ☐ 12 weeks ☐ Other_____
☐ Zepatier (elbasvir/grazoprevir)	Fixed dose combination tablet of 50 mg elbasvir / 100 mg grazoprevir	Take one tablet once daily with or without food.	Quantity: 28-day supply Refills: ☐ 12 weeks ☐ 16 weeks

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

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