Hepatitis - C Enrollment Form

Phone: 800-361-1260
Fax: 800-737-4920

CORNERSTONE PHARMACY
an affiliate of

PATIENT INFORMATION

Patient Name			☐ Male ☐ Female
Date of Birth	SS#	Phone (Home)	(Work)
Address		City	State / Zip

PHARMACY INSURANCE INFORMATION (PLEASE ATTACH COPY OF PATIENT CARD – FRONT AND BACK)

Primary Insurance		Policy Holder
Policy #	Group #	Phone

CLINICAL DIAGNOSIS / MEDICAL INFORMATION (Indicate primary and secondary diagnosis – include lab reports and clinical notes)

☐ B18.2 Hepatitis – C (Chronic) ☐ Other ICD10 Initial Viral Load - HCV RNA: __________ IU/mL Date: __________

Genotype: ☐ 1 ☐ 1a* ☐ 1b ☐ 2 ☐ 2a ☐ 2b ☐ 3 ☐ 3a ☐ 3b ☐ 4 ☐ 4a ☐ 4b ☐ 5 ☐ 6 ☐ Other
*1a - Is the Q80K polymorphism present? ☐ Yes ☐ No

Date of Diagnosis: ___________ ☐ Treatment Naive ☐ Previous Treatment ______________ ☐ Non-Responder ☐ Partial-Responder ☐ Relapser
Duration of Prior Treatment from: ______________ to: ______________ Total weeks: ______________

HIV Co-Infected ☐ Yes ☐ No HBV Co-Infected ☐ Yes ☐ No Cirrhosis ☐ Yes ☐ No if, Yes: ☐ Compensated ☐ Decompensated
Concomitant medications: ____________________________ Other Health Conditions: ____________________________

Liver Biopsy ☐ Yes ☐ No Metavir Score ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4 Transplant recipient ☐ Yes ☐ No Awaiting transplant ☐ Yes ☐ No

Patient Weight: ____________ kg. OR ______________ lbs. Drug Allergies: _________________________ or ☐ NKDA

PRESCRIPTION INFORMATION

Rx-Medication	*Dose*	*Instructions and Frequency*	*Quantity*	*Refills*
☐ **Daklinza** (daclatasvir)	☐ 30 mg tablet ☐ 60 mg tablet	Take 1 tablet by mouth daily with or without food	28 Day Supply	
☐ **Epclusa™** (sofosbuvir /velpatasvir)	☐400 mg/100 mg tablet	Take 1 tablet by mouth daily with or without food	28 Day Supply	
☐ **Harvoni™** (ledipasvir/sofosbuvir)	☐90 mg/400 mg tablet	Take 1 tablet by mouth daily with or without food	28 Day Supply	
☐ **Olysio™** (simeprevir)	☐150 mg capsule	Take 1 capsule by mouth daily with food	28 Day Supply	
☐ **Moderiba®** (ribavirin) or ☐ **RibaPak®** (ribavirin)	☐ 600mg tablet ☐ 800mg tablet ☐ 1000mg tablet ☐ 1200mg tablet	☐ 200mg Every Morning, 400mg Every Evening ☐ 400mg Every Morning, 400mg Every Evening ☐ 600mg Every Morning, 400mg Every Evening ☐ 600mg Every Morning, 600mg Every Evening	28 Day Supply	
☐ **Ribavirin, Generic**	☐ 200 mg tablet	Weight Based	28 Day Supply	
☐ **Sovaldi™** (sofosbuvir)	☐400 mg tablet	Take 1 tablet by mouth daily with or without food	28 Day Supply	
☐ **Technivie** (ombitasvir/paritaprevir/ritonavir)	☐ 12.5-75-50mg Tab	Take 1 tablet by mouth daily with a meal	28 Day Supply	
☐ **Viekira Pak** (ombitasvir/paritaprevir/ritonavir tablets copackaged with dasabuvir tablets)	☐ 12.5mg /75mg /50mg /250mg tablet	Take 2 ombitasvir, paritaprevir, ritonavir tablets (pink tablets) once daily (in the morning) and 1 dasabuvir (beige tablet) twice daily (morning & evening) with a meal without regard to fat or calorie	28 Day Supply	

DELIVERY AND PATIENT EDUCATION INSTRUCTIONS

☐ Patient's Home	☐ Physician's Office	Date Needed:	Patient needs Education Kit? ☐ yes ☐ no

PHYSICIAN CONTACT INFORMATION AND AUTHORIZATION

Physician Name	License #	DEA #	UPIN #
Office Contact	Phone	Fax	NPI#
Address		City/State/Zip	
Physician's Signature		Date (required)	

This prescription will be filled generically unless prescriber writes "DAW" in the box to the right.