Hepatitis C Enrollment Form

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MAXOR® SPECIALTY

PATIENT INFORMATION

Patient Name _____
Date of Birth _____ ◯ Male ◯ Female
Street Address _____ Apt # _____
City _____ State _____ Zip _____
Phone-Primary _____ Secondary _____
◯ English ◯ Spanish ◯ Other _____
Email Address _____
Social Security # _____
◯ NKDA Known Drug Allergies _____
Weight _____ kg/lb Height _____ in/cm

Please attach front and back of patient's insurance cards

PRESCRIBER INFORMATION

Physician Name _____
NPI _____ License # _____
Office Contact _____
Street Address _____ Ste # _____
City _____ State _____ Zip _____
Phone _____ Fax _____

By signing this form, I authorize Maxor Specialty to act as my agent for prior authorizations & prescription reimbursement for the above listed patient.
Physician Signature _____
Date _____
◯ Dispense as written ◯ Product substitution permitted

** For Ohio patients, please only choose one (1) prescription/form.**

CLINICAL INFORMATION

◯ B18.2 Chronic Hepatitis C ◯ K72.90 ◯ K72.91 Hepatic Encephalopathy ◯ C22.0 ◯ C22.2 ◯ C22.7 ◯ C22.8 Hepatocellular Carcinoma
◯ Other _____
Genotype: _____ NS5A RAVs ◯ Yes ◯ No Viral load: _____ IU/ml Viral load date: _____
◯ Treatment naïve ◯ Previously treated: Prior treatment used: _____ ◯ Non-responder ◯ Responder/Relapser
Duration of previous therapy: From _____ to _____ Total of: _____ months HIV Coinfected: ◯ Yes ◯ No HBV Coinfected: ◯ Yes ◯ No
Compensated Liver Disease: ◯ Yes ◯ No Cirrhosis: ◯ Yes ◯ No Metavir Score: _____
Solid Organ Transplant recipient: ◯ Yes ◯ No Awaiting liver transplant: ◯ Yes ◯ No

PRESCRIPTION INFORMATION

CHECK TO ENROLL IN PATIENT ASSISTANCE PROGRAM ◯

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
◯ **Daklinza™ (daclatasvir)**	◯ 30mg ◯ 60mg ◯ 90mg	Take one tablet PO QD with or without food *Must be taken in combination with sofosbuvir	28 day supply	
◯ **Epclusa®**	400mg/100mg tablet	Take one tablet PO QD with or without food ◯ Genotype 1, 2, 3, 4, 5, 6 with cirrhosis; 12 wks ◯ Genotype 1, 2, 3, 4, 5, 6 with decompensated cirrhosis: 12 wks + Ribavirin 12 wks Ribavirin: If <75kg: give 500mg PO twice daily If >75kg: give 600mg PO twice daily	28 tablets	
◯ **Harvoni® (ledipasvir/sofosbuvir)**	90/400mg tablet	Take one tablet PO QD with or without food ◯ Naïve without cirrhosis who have a pretreatment HCV RNA <6 million IU/ml; 8 wks ◯ Naïve with or without cirrhosis; 12 wks ◯ Experienced without cirrhosis; 12 wks ◯ Experienced with cirrhosis; 24 wks	28 day supply	
◯ **Olysio® (simeprevir)**	150mg capsule	Take 150mg (1 capsule) PO QD with food *Monotherapy not recommended	28 day supply	
◯ **Riba-pak®**	◯ 600mg ◯ 800mg ◯ 1000mg ◯ 1200mg	◯ 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	
◯ **Ribasphere®**	200mg		28 day supply	
◯ **Sovaldi® (sofosbuvir)**	400mg tablet	Take 400mg (1 tablet) PO QD with or without food *Monotherapy not recommended	28 day supply	
◯ **Technivie™ (ombitasvir/paritaprevir/ritonavir)**	12.5/75/50mg	Take two fixed dose combination tablets daily in the morning *Must be taken with ribavirin	28 day supply	
◯ **Viekira Pak® (Ombitasvir/Paritaprevir/ritonavir/dasabuvir)** ◯ **Viekira XR® (dasabuvir/ombitasvir/paritaprevir/ritonavir)**	12.5/75/50/250 mg 200/8.33/50/33.33mg	Take daily as directed ◯ Genotype 1A without cirrhosis Viekira Pak + ribavirin or Viekira XR + ribavirin; 12 wks* ◯ Genotype 1A with compensated cirrhosis Viekira Pak + ribavirin or Viekira XR + ribavirin; 24 wks ◯ Genotype 1B without cirrhosis Viekira Pak or Viekira XR; 12 wks** ◯ Genotype 1B with compensated cirrhosis Viekira Pak or Viekira XR; 12 wks** *For liver transplant patients with normal hepatic function and mild fibrosis increase to 24 wks **For liver transplant patients with normal hepatic function and mild fibrosis add ribavirin and increase to 24 wks	28 day supply	
◯ **Zepatier™ (elbasvir/grazoprevir)**	50/100mg tablet	Take one tablet PO QD with or without food; 12 wks Genotype 1a NS5A resistance-associated polymorphisms are present, administer with ribavirin and extend therapy to 16 wks	28 day supply	

Date meds needed: _____ ◯ New ◯ Refill
Ship to: ◯ Patient's home ◯ Physician's Office ◯ Other _____