Hepatitis C Enrollment Form
Medications A-E
(Epclusa®)

CVS specialty®

Fax Referral To: 1-877-552-2907
Email Referral To: customerservicefax@caremark.com
Phone: 1-888-345-1678

Six Simple Steps to Submitting a Referral

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

Patient Name: _____ Address: _____ City, State, ZIP: _____
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: _____ DOB: _____ Gender: ☐ Male ☐ Female
Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
NPI #: _____ DEA #: _____ Group or Hospital: _____
Address: _____ City, State, ZIP: _____
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 _____

For additional ICD-10 information, please visit CVS Specialty Healthcare Professionals Website
https://www.cvsspecialty.com/wps/portal/specialty/healthcare-professionals/about-us

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:_____

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

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)
X_____ X_____

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 below, 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 F-V
Hepatitis C Enrollment Form

(Harvoni®, Ledipasvir/Sofosbuvir, Mavyret™, Pegasys®, Pegintron®, Ribavirin, Ribasphere®, Sofosbuvir/Velpatasvir, Sovaldi®, Technivie™, Viekira Pak™)

Please complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	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.	Quantity: 28-day supply Refills: ☐ 8 weeks ☐ 12 weeks ☐ 24 weeks
☐ Mavyret (glecaprevir and pibrentasvir)	Fixed-dose combination tablet of 100mg glecaprevir and 40mg pibrentasvir	Take three tablets PO once a day 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:_____
☐ 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

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

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X_____ X_____

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Medications V-Z
Hepatitis C Enrollment Form
(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
☐ 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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X_____ X_____

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