Hepatitis C Enrollment Form

CVS specialty®

Fax Referral To: 1-877-232-5455
Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813

Phone: 1-808-254-2727
NCPDP: 1203417

Six Simple Steps to Submitting a Referral

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

Patient Name: _____ DOB: _____ Gender: ☐ Male ☐ Female
Address: _____City, State, ZIP Code: _____
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____
Parent/Caregiver/Legal Guardian Name (Last, First): _____**Relationship to patient**: _____

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)

Is the Patient Insured? ☐ Yes ☐ No Is the Patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ No
Policy Holder's Name:_____ Policy Holder's DOB:_____ Relationship to Patient:_____
Medical Insurance: _____ Telephone: _____ Policy ID: _____ Group #: _____
Prescription Insurance: _____ Prescription Plan Telephone: _____
Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #:_____
☐ Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# _____

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

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Epclusa Tablet (sofosbuvir and velpatasvir)	Fixed-dose combination tablet of 400 mg sofosbuvir / 100 mg velpatasvir	Take one tablet once daily.	Quantity: _____ Refills: _____
☐ Epclusa Oral Pellets (sofosbuvir and velpatasvir)	☐ Unit-dose pellet packets of 200 mg sofosbuvir and 50 mg velpatasvir ☐ Unit-dose pellet packets of 150 mg sofosbuvir and 37.5 mg velpatasvir	_____ kg / lb (please circle) ☐ Mix ____ packet(s) of oral pellets with a small amount of soft food and swallow once daily ☐ Pour ____ packet(s) of oral pellets directly into the mouth and swallow once daily ☐ Other: _____	Quantity: 28-day supply Refills: ☐ 12 weeks ☐ Other: _____

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

Hepatitis C Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____
Patient Address:_____
Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Harvoni (ledipasvir and 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
☐ 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 Pellets (glecaprevir and pibrentasvir)	Unit-dose pellet packets of 50 mg glecaprevir and 20 mg pibrentasvir	_____ kg / lb (please circle) ☐ Mix __ packet(s) of oral pellets with a small amount of soft food and swallow once daily ☐ Other: _____	Quantity: 28-day supply Refills: ☐ 8 weeks ☐ 12 weeks ☐ Other_____
☐ 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: _____
☐ Sovaldi (sofosbuvir)	☐ 400 mg tablets	Take one 400 mg tablet PO once a day.	Quantity: 28-day supply 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 and grazoprevir)	Zepatier (elbasvir/grazoprevir)	Take one tablet once daily with or without food.	Quantity: 28-day supply Refills: ☐ 12 weeks ☐ 16 weeks

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