

Hepatitis C Enrollment Form

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Fax Referral To: 1-877-232-5455 Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813 nla Stone to Submitting a Br

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

	TION (Complete or include de	mographic shee	et)		
				Gender: 🗌 Male 🗌	Female
Address:			y, State, ZIP Code:		
Note: Carrier charges may ap	Phone (to primary # provide pply. By providing the phone nur	ed below) 🗌 Te	xt (to cell # provided bel ail address above, you are	ow) 🗌 Email (to email prov consenting to receive auto	omated calls,
	from CVS Specialty® about you				ly. Message
	contact via text or email, Specia			phone.	
Email:		_ Last Four of S	SN: Primary L	anguage:	
	rdian Name (Last, First):	R	elationship to patient: _		
PRESCRIBER INFOR					
Prescriber's Name:	Group or Hospita		State License #:		
NPI #: DEA #:	Group or Hospita	al:			
\ddress:	FaxCo	City	, State, ZIP Code:		
INSURANCE INFOR	MATION Please fax copy of p	rescription and i	nsurance cards with this fo	rm, if available (front and back)	
s the Patient Insured?	Yes 🗌 No 🛛 Is the Patient enro	olled or eligible	e for Medicare/Medicaid	l? □Yes □ No	
Policy Holder's Name:		Policy Hold	ler's DOB:	_ Relationship to Patient:_	
	Tele				
Prescription Insurance:		-	Prescription Plan Te	lephone:	
Policy ID:	Group #:		RX BIN #:	RX PCN #:	
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DIAGNOSIS AND CI	LINICAL INFORMATION	1			
	Ship to: 🗌 Pa		Other:		
Diagnosis (ICD-10):	·				
B17.10 Acute Hepatitis C	without hepatic coma 🛛 🗌 B	17.11 Acute Hep	atitis C with hepatic com	a	
B18.2 Chronic Hepatitis C			ed Viral Hepatitis C witho		
B20 HIV		ther Code:	Description	-	
Dationt Clinical Information					
Patient Clinical Information	<u>:</u>		,		
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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 DOB:	Patier

_____ Prescriber Phone: ______

Patient Name: Patient Address:

Prescriber Name:

Patient 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	

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 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.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments. Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates.