



# Hepatitis C Enrollment Form

Fax Referral To: 1-855-297-1270

Phone: 1-888-280-1190

Address: 6020 Ave Roberto Sanchez Vilella Carolina, PR 00982

NCPDP: 4026325

## 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
<input type="checkbox"/> Epclusa Tablet (sofosbuvir and velpatasvir)	Fixed-dose combination tablet of 400 mg sofosbuvir / 100 mg velpatasvir	Take one tablet once daily.	Quantity: _____ Refills: _____
<input type="checkbox"/> Epclusa Oral Pellets (sofosbuvir and velpatasvir)	<input type="checkbox"/> Unit-dose pellet packets of 200 mg sofosbuvir and 50 mg velpatasvir <input type="checkbox"/> Unit-dose pellet packets of 150 mg sofosbuvir and 37.5 mg velpatasvir	_____ kg / lb (please circle) <input type="checkbox"/> Mix _____ packet(s) of oral pellets with a small amount of soft food and swallow once daily <input type="checkbox"/> Pour _____ packet(s) of oral pellets directly into the mouth and swallow once daily <input type="checkbox"/> Other: _____	Quantity: 28-day supply Refills: <input type="checkbox"/> 12 weeks <input type="checkbox"/> 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

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.

# 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
<input type="checkbox"/> 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: <input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks
<input type="checkbox"/> 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: <input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> Other _____
<input type="checkbox"/> Mavyret Oral Pellets (glecaprevir and pibrentasvir)	Unit-dose pellet packets of 50 mg glecaprevir and 20 mg pibrentasvir	_____ kg / lb (please circle) <input type="checkbox"/> Mix _____ packet(s) of oral pellets with a small amount of soft food and swallow once daily <input type="checkbox"/> Other: _____	Quantity: 28-day supply Refills: <input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> Other _____
<input type="checkbox"/> Ribavirin	<input type="checkbox"/> 200 mg tablets <input type="checkbox"/> 200 mg capsules	Take _____ tabs/caps PO q am and _____ tabs/caps q pm for a total of _____ mg daily with food.	Quantity: _____ Refills: _____
<input type="checkbox"/> Sovaldi (sofosbuvir)	<input type="checkbox"/> 400 mg tablets	Take one 400 mg tablet PO once a day.	Quantity: 28-day supply Refills: _____
<input type="checkbox"/> 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: <input type="checkbox"/> 12 weeks <input type="checkbox"/> Other _____
<input type="checkbox"/> Zepatier (elbasvir and grazoprevir)	Zepatier (elbasvir/grazoprevir)	Take one tablet once daily with or without food.	Quantity: 28-day supply Refills: <input type="checkbox"/> 12 weeks <input type="checkbox"/> 16 weeks

Patient is interested in patient support programs

**STAMP SIGNATURE NOT ALLOWED**

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"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____
<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words "No Substitution" _____ <b>ATTN: New York and Iowa providers,</b> 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.

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