TFP WELLNESS SYSTEMS

Your Lifetime Pharmacy Solution

HEPATITIS C
ENROLLMENT FORM

Phone: 813-871-5161 Ext. 34993 **Fax: 813-877-2479**

PATIENT INFORMATION *(COMPLETE THE FOLLOWING OR ATTACH PATIENT DEMOGRAPHIC SHEET)*

Patient Name	☐ Male ☐ Female	Allergies	
Date of Birth	SSN#	Patient Weight Height Date	
Address	City	State	Zip
Phone # (Home)	(Work/Cell)	Email address	

INSURANCE INFORMATION *(COMPLETE THE FOLLOWING OR COPY AND ATTACH THE FRONT AND BACK OF INSURANCE AND PRESCRIPTION DRUG CARD)*

Primary Insurance		Policyholder
Group #	Policy #	Phone #
Secondary Insurance	Policy#	Phone #

DIAGNOSIS/CLINICAL INFORMATION *(PLEASE SEND RECENT CLINICAL NOTES, LABS, & CURRENT MEDICATIONS TO EXPIDITE THE PRIOR AUTHORIZATION)*

☐ B18.2 Hepatitis C (Chronic)	☐ Other ICD-10 _____	Genotype: _____	HCV/HBV viral load _____IU/ml Date of Last Labs_____/____/_____ HIV Co-Infection? ☐Yes ☐ No

Is patient: ☐Naïve ☐Partial Responder ☐ Non- Responder ☐ Relapser ☐ Interferon Intolerant ☐ Ribavirin Intolerant

NS5A RAVs: ☐ Yes ☐ No Previous Treatment & Date: _____

Liver Biopsy performed? ☐ Yes ☐ No **Fibrosure Performed** ☐ Yes ☐ No **Fibroscan Performed** ☐ Yes ☐ No _____ KPa

Fibrosis Score _____

Does patient have chronic HCV w/compensated liver disease? ☐ Yes ☐ No Is patient cirrhotic? ☐ Yes ☐ No

PRESCRIPTION INFORMATION *(COMPLETE DRUG THERAPY INFORAMTION OR ATTACH COMPLETED PRESCRTIPTION)*

Medication	Dose	Frequency	Quantity	Refill
☐ EPCLUSA® (sofosbuvir & velpatasvir)	☐ 400mg/100 mg tablet	☐ orally one time daily for 12 weeks	28 day supply	
☐ MAVYRET™ (glecaprevir 100 mg & pibrentasvir 40 mg)	☐ 300mg/120 mg 3 tablet regimen	☐ orally one time daily w/food for 8 weeks ☐ orally one time daily w/food for 12 weeks ☐ orally one time daily w/food for 16 weeks	28 day supply	
☐ HARVONI® (ledipasvir & sofosbuvir)	☐ 90mg/400 mg tablet	☐ orally one time daily for 8 weeks ☐ orally one time daily for 12 weeks ☐ orally one time daily for 24 weeks	28 day supply	
☐ ZEPATIER® (elbasvir & grazoprevir)	☐ 50mg/100 mg tablet	☐ orally one time daily for 12 weeks ☐ orally one time daily for 16 weeks	28 day supply	
☐ VOSEVI™ (sofosbuvir 400 mg/velpatasvir 100 mg/voxilaprevir 100 mg)	☐ 400mg/100mg/100mg tablet	☐ orally one time daily w/food for 12 weeks	28 day supply	
☐ Ribavirin 200mg capsules or tablets	Take _____ PO in AM & _____ PO in PM		28 day supply	
☐ Other: _____	Dose:_____	Frequency:_____		

DELIVERY INSTRUCTIONS

☐ Provider's Office ☐ Patient's Home
☐ 1st dose to Provider's Office, refills to patient home

Requested Therapy Start Date: _____/_____/_____

PROVIDER CONTACT INFORMATION & AUTHORIZATION

Provider Name:	Office Contact:	Email:
Phone:	Fax:	Institution:
Address:		City:
License #	Tax ID:	NPI #

Provider's Signature _____ **Date** _____

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

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