Hepatitis C Enrollment Form **Medications A-L**

(Epclusa, Harvoni, Ledipasvir/Sofosbuvir)



Fax Referral To: 1-877-232-5455 Address: 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813 NCPDP: 1203417

Phone: 1-800-896-1464

	Six Simple Steps t	o Submitting a Referral	
PATIENT INFORMATIC	DN (Complete or include demograph		
		DOB:	
Address:		City, State, ZIP Code:	
Gender: 🗌 Male 🔲 Female			
Preferred Contact Methods: [Phone (to primary # provided below	v) 🗌 Text (to cell # provided below) 🗌 Er	mail (to email provided below)
Note: Carrier charges may ap	ply. If unable to contact via text or ema	il, Specialty Pharmacy will attempt to cont	act by phone.
Primary Phone:		Alternate Phone:	
f Minor , Parent/Caregiver/G	uardian Name (Last, First):		
Relationship to minor:			
<u> </u>		Last Four of SSN: Primary L	anguage:
PRESCRIBER INFORM	ATION		
Prescriber's Name:		State License #:	
NPI #: DEA #:	Group or Hospital:		
Address:		City, State, ZIP Code: Person: Conta	
Phone:	Fax Contact F	Person: Conta	act's Phone:
INSURANCE INFORM	ATION Please fax copy of prescription a	and insurance cards with this form, if availab	le (front and back)
DIAGNOSIS AND CLIN			
		Office 🗌 Other:	
Diagnosis (ICD-10):			
B17.10 Acute Hepatitis C v	vithout hepatic coma 🛛 🗍 B17.11 Ac	ute Hepatitis C with hepatic coma	
B18.2 Chronic Hepatitis C		nspecified Viral Hepatitis C without hepati	c coma
B20 HIV		de: Description	
Patient Clinical Information			
Allergies:		eight:lb/kg Height:in/c	m
		No Cirrhosis Compensated Cirrhosis	
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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.

Medications M-S

Hepatitis C Enrollment Form

(Mavyre	t, Pegasys, Pegintron, Ribavirin, Rib	asphere RibaPak , Sofosbuvir/Velpatasvir,	Sovaldi)
	Please Complete Patie	nt and Prescriber Information	
Patient Name:		Patient DOB:	
Prescriber Name:			
5 PRESCRIPTION IN	IFORMATION		
MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
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 Pellet (glecaprevir and pibrentasvir)	Fixed-dose combination oral pellet of 50 mg glecaprevir and 20 mg pibrentasvir	 kg/lb Take three packets of oral pellets PO once daily with food. Take four packets of oral pellets PO once daily with food. Take five packets of oral pellets PO once daily 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.	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:

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:	t Substitute / No Substitution /Date:	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature:	Date:
CA, MA, NC & PR: Interchange is mandated unless Prescriber w	rites the words " No Substitution "	ATTN: New York and Iowa provide	rs, 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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Medications M-Z Hepatitis C Enrollment Form

(Technivie, Viekira Pak, Vosevi, Zepatier)

Please Complete Patient and Prescriber Information

Patient Name:
Prescriber Name:

Patient DOB: Prescriber Phone:

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS	
Technivie	Fixed dose combination tablet of		Quantity: 28-day supply	
(ombitasvir/paritaprevir	ombitasvir / paritaprevir / ritonavir	Take two tablets once daily in the morning.	Refills:12 weeks	
/ritonavir)	12.5 mg / 75 mg / 50 mg			
🗌 Viekira Pak	Copackaged ombitasvir / partiaprevir	Take 2 pink tablets (ombitasvir,	Quantity: 28-day supply	
(ombitasvir/paritaprevir		paritaprevir, ritonavir) once daily (morning)	Refills:	
/ritonavir tabs and	/ ritonavir 12.5 mg / 75 mg / 50 mg	and 1 beige tablet (dasabuvir) twice daily	🗌 12 weeks	
dasabuvir tabs)	and dasabuvir 250 mg	(morning and evening) with meals.	24 weeks	
Vosevi	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	
(sofosbuvir, velpatasvir,			Refills:	
, , ,			🗌 12 weeks	
and voxilaprevir)			Other	
			Quantity: 28-day supply	
Zepatier	Fixed dose combination tablet of 50	Take one tablet once daily with or without	Refills:	
(elbasvir/grazoprevir)	mg elbasvir / 100 mg grazoprevir	food.	🗌 12 weeks	
			16 weeks	

STAMP SIGNATURE NOT ALLOWED Patient is interested in patient support programs 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

Prescriber's Signature: Date:	
DAW / May Not Substitute Substitution Permissible	
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product Selection Permitted /	

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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Ancillary supplies and kits provided as needed for administration