

Hepatitis C Enrollment Form

Medications A-E

(Eplclusa®)



Fax Referral To: 1-877-552-2907

Email Referral To: customerservicefax@caremark.com

Phone: 1-888-345-1678

Six Simple Steps to Submitting a Referral

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

Patient Name: _____ Address: _____ City, State, ZIP: _____
 Preferred Contact Methods: Phone (to primary # provided below) Text (to cell # provided below) Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
 Primary Phone: _____ Alternate Phone: _____ DOB: _____ Gender: Male Female
 Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
 NPI #: _____ DEA #: _____ Group or Hospital: _____
 Address: _____ City, State, ZIP: _____
 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)

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: _____

For additional ICD-10 information, please visit [CVS Specialty Healthcare Professionals Website](https://www.cvsspecialty.com/wps/portal/specialty/healthcare-professionals/about-us)

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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

Nursing:

Specialty pharmacy to coordinate injection training/home health nurse visit as necessary? Yes No
 Site of Care: MD office Infusion Clinic Outpatient Health Home Health
 Injection training not necessary. Date training occurred: _____
 Reason: MD office training patient Pt already independent Referred by MD to alternate trainer

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Eplclusa (sofosbuvir / velpatasvir)	Fixed-dose combination tablet of 400 mg sofosbuvir / 100 mg velpatasvir	Take one tablet once daily.	Quantity: _____ Refills: _____

Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

X _____ X _____

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 below, 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 F-Z

Hepatitis C Enrollment Form

(Harvoni®, Mavyret™, Pegasys®, Peginteron®, Ribavirin, Ribasphere®,
Sovaldi®, Technivie™, Viekira Pak™, Vosevi™, Zepatier)

Please complete Patient and Prescriber information

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

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Harvoni (ledipasvir/ 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 (glecaprevir and pibrentasvir)	Fixed-dose combination tablet of 100mg glecaprevir and 40mg 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"/> Pegasys (peginterferon alfa-2a)	<input type="checkbox"/> 180 mcg / 0.5 mL ProClick™ Autoinjector <input type="checkbox"/> Other: _____	<input type="checkbox"/> Inject 180 mcg SC once a week as directed. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Peginteron (peginterferon alfa-2b)	<input type="checkbox"/> 120 mcg REDIPEN® <input type="checkbox"/> 150 mcg REDIPEN <input type="checkbox"/> Other: _____	<input type="checkbox"/> Inject _____ mcg SC weekly. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<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"/> Ribasphere RibaPak® (ribavirin)	<input type="checkbox"/> 600 / 600 mg <input type="checkbox"/> 600 / 400 mg <input type="checkbox"/> 400 / 400 mg <input type="checkbox"/> 200 / 400 mg	Take _____ mg PO q am and _____ mg 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"/> Technivie (ombitasvir/paritaprevir/rit onavir)	Fixed dose combination tablet of ombitasvir / paritaprevir / ritonavir 12.5 mg / 75 mg / 50 mg	Take two tablets once daily in the morning.	Quantity: 28-day supply Refills: 12 weeks
<input type="checkbox"/> Viekira Pak (ombitasvir/paritaprevir/rit onavir tabs and dasabuvir tabs)	Copackaged ombitasvir / paritaprevir / ritonavir 12.5 mg / 75 mg / 50 mg and dasabuvir 250 mg	Take 2 pink tablets (ombitasvir, paritaprevir, ritonavir) once daily (morning) and 1 beige tablet (dasabuvir) twice daily (morning and evening) with meals.	Quantity: 28-day supply Refills: <input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks
<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/grazoprevir)	Fixed dose combination tablet of 50 mg elbasvir / 100 mg 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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PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

X _____ **X** _____

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