Carepoint™
A Pharmacy That Truly Cares

Hepatitis C Therapy Enrollment

www.carepointrx.com
Fax: 855-237-9113 | Toll Free: 855-237-9112
E-Prescribe: NCPDP 1487330 | NPI 1598013864

PATIENT

PLEASE INCLUDE FACE SHEET & ALL CLINICAL NOTES

Name ______________________ DOB ____________ Phone ________________

Address ______________________ City, State ________________ Zip ________

MEDICAL ASSESSMENT

DATE: ____________ Height & Weight: ____________ Allergies: ____________________

Diagnosis: ☐ B18.2 Chronic Hepatitis C Virus ☐ ____________________
Co-infection: ☐ None ☐ HIV ☐ HBV
Viral Load: ____________________ **Date:** ____________________
Cirrhosis: ☐ None ☐ Comp'd ☐ Decomp'd
Genotype: ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
Fibrosis Score: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4
Child-Pugh Class: ☐ A ☐ B ☐ C
CKD Stage: ☐ N/A ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
NS5A polymorphism: ☐ Yes ☐ No
Type: ☐ M28 ☐ Q30 ☐ L31 ☐ Y93 ☐ ______
Dialysis: ☐ Yes ☐ No
IL-28: ☐ CC ☐ CT ☐ TT
Transplant: ☐ N/A ☐ Pre ☐ Post

Prior Therapies:	Reason for Discontinuation:	Appx. Start Date:	Appx. End Date:

PRESCRIPTION

Quantity/Refills

Harvoni® (ledipasvir/sofosbuvir)	90mg/400mg tablets	☐ Take 1 tablet by mouth once daily, with or without food	4 weeks / ______
Sovaldi® (sofosbuvir)	400mg tablets	☐ Take 1 tablet by mouth once daily, with or without food	4 weeks / ______
Daklinza® (daclatasvir)	☐ 30mg ☐ 60mg tablets	☐ Take 1 tablet by mouth once daily, with or without food	4 weeks / ______
Olysio® (simeprevir)	150mg capsules	☐ Take 1 capsule by mouth once daily, with food	4 weeks / ______
Pegasys® (peginterferon alfa-2a)	☐ 135mcg/0.5ml Proclick ☐ 180mcg/0.5ml Proclick ☐ 180mcg/0.5ml PFS ☐ 180mcg/ml vial	Inject: ☐ 135mcg ☐ 180mcg ☐ ______ mg subcutaneously once weekly	4 weeks / ______
Technivie® (ombitasvir/paritaprevir/ritonavir)	12.5mg / 75mg / 50mg tabs	☐ Take 2 tablets by mouth every morning with food	4 weeks / ______
Viekira Pak® (ombitasvir/paritaprevir/ritonavir packaged with dasabuvir)	12.5mg/75mg/50mg/250mg tabs	☐ Take 2 ombi/pari/rit tablets (pink) and 1 dasabuvir tablet (beige) every morning and one dasabuvir tablet (beige only) every evening with food	4 weeks / ______
Zepatier® (elbasvir/grazoprevir)	50mg / 100mg tablets	☐ Take 1 tablet by mouth once daily, with or without food	4 weeks / ______
Choose: ☐ **RibaSphere®** ☐ **ribavirin**	200mg capsules	☐ Take ______ mg P.O. every AM and ______ mg every PM	4 weeks / ______
Choose: ☐ **RibaPak®** ☐ **Moderiba®**	☐ 600mg/day ☐ 800mg/day ☐ 1000mg/day ☐ 1200mg/day	☐ Take 200mg P.O. every morning and 400mg every evening ☐ Take 400mg P.O. every morning and 400mg every evening ☐ Take 600mg P.O. every morning and 400mg every evening ☐ Take 600mg P.O. every morning and 600mg every evening	4 weeks / ______
OTHER:	☐ ____________________	SIG: ______________________________ ______________________________	4 weeks / ______

☒ Dispense sufficient quantity of all necessary supplies (syringes, needles, alcohol wipes, etc.) for proper medication administration

PROVIDER

PLEASE INCLUDE FRONT AND BACK OF ALL INSURANCE CARDS

Prescriber Name ______________________ Phone ______________ Fax ________________

________________________ (________________) ________________________

Prescriber Signature ***NPI or DEA*** ***In-Office Contact Person***

**By signing this form and utilizing our services, you authorize Carepoint and its employees to serve as your designated agent for handling prior authorizations and other medical and prescription insurance forms and communications*

FORM_106.0516