



Hepatitis C Enrollment Form (A-S)

www.pyramidspharmacy.com

All our referral forms are available on our website.

500 N. Kobayashi Road, Suite D | Webster, TX 77598 | Phone: 1.855.889.9964 | Fax: 1.888.383.2140

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs. kg.
 Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

Plan Name: _____ Plan Phone: _____
 ID #: _____ Group #: _____ RxBIN: _____ RxPCN: _____

2: Prescriber Information

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
 Address: _____ Phone: (____) _____ - _____ Fax: (____) _____ - _____
 City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (____) _____ - _____

3: Diagnosis/Clinical Information | Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization

Diagnosis (ICD-10):
 B18.2 Chronic Hepatitis C
 B20 HIV
 C22.0 Liver Cell Carcinoma
 Other: _____
 HCV genotype: _____
 HCV RNA: _____ IU/mL
 Date of lab: _____

Fibrosis Score: _____
 No cirrhosis
 Compensated cirrhosis
 Decompensated cirrhosis
 Liver transplant? Yes No
 Waiting for liver transplant? Yes No
 HBV coinfection? Yes No

Is patient:
 Naïve Partial responder
 Null responder Relapsed
 Previous therapy: _____

NS5A Polymorphism?
 Yes No Unknown

4: Prescription Information

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Daklinza™ (daclatasvir)	<input type="checkbox"/> 30 mg Tablet <input type="checkbox"/> 60 mg Tablet	<input type="checkbox"/> Take one tablet by mouth once daily with sofosbuvir (Sovaldi®), with or without food. <i>(Note: Add ribavirin for decompensated)</i>	28 day supply	<input type="checkbox"/> 12 Weeks <input type="checkbox"/> Other: _____
<input type="checkbox"/> Eplclusa® (sofosbuvir/velpatasvir)	<input type="checkbox"/> 400/100 mg Tablet	<input type="checkbox"/> Take one tablet by mouth once daily, with or without food. <i>(Note: Add ribavirin for decompensated)</i>	28 day supply	<input type="checkbox"/> 12 Weeks <input type="checkbox"/> Other: _____
<input type="checkbox"/> Harvoni® (ledipasvir/sofosbuvir)	<input type="checkbox"/> 90/400 mg Tablet	<input type="checkbox"/> Take one tablet by mouth once daily, with or without food. <i>(Note: Add ribavirin for decompensated)</i>	28 day supply	<input type="checkbox"/> 8 Weeks <input type="checkbox"/> 12 Weeks <input type="checkbox"/> 24 Weeks <input type="checkbox"/> Other: _____
<input type="checkbox"/> Mavyret™ (glecaprevir/pibrentasvir)	<input type="checkbox"/> 100/40 mg Tablet	<input type="checkbox"/> Take 3 tablets by mouth once daily with food. <i>(Note: Not recommended in CTP B; contraindicated in CTP C)</i>	28 day supply	<input type="checkbox"/> 8 Weeks <input type="checkbox"/> 12 Weeks <input type="checkbox"/> 16 Weeks <input type="checkbox"/> Other: _____
<input type="checkbox"/> Ribavirin	<input type="checkbox"/> 200 mg Tablet <input type="checkbox"/> 200 mg Capsule	<input type="checkbox"/> Take _____ tablets/capsules by mouth every morning and _____ tablets/capsules every evening with food.	28 day supply	<input type="checkbox"/> 8 Weeks <input type="checkbox"/> 12 Weeks <input type="checkbox"/> 24 Weeks <input type="checkbox"/> Other: _____
<input type="checkbox"/> Sovaldi® (sofosbuvir)	<input type="checkbox"/> 400 mg Tablet	<input type="checkbox"/> Take one tablet by mouth once daily, with or without food. <i>(Note: Administered with ribavirin and/or daclatasvir)</i>	28 day supply	<input type="checkbox"/> 12 Weeks <input type="checkbox"/> 24 Weeks <input type="checkbox"/> Other: _____

Deliver to: Patient Office Other: _____ Date: _____ Needs by 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.

Product Substitution Permitted Dispense as Written

STAMP SIGNATURE NOT ALLOWED

Prescriber's Signature: _____ Date: _____

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.



Hepatitis C Enrollment Form (T-Z)

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 Null responder Relapsed
 Previous therapy: _____
 NS5A Polymorphism?
 Yes No Unknown

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Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Viekira Pak® <small>(ombitasvir/paritaprevir/ritonavir with dasabuvir)</small>	<input type="checkbox"/> 12.5/75/50 mg Tablet and 250 mg Tablet	<input type="checkbox"/> Take 2 pink tablets and 1 beige tablet by mouth every morning and 1 beige tablet every evening with meals as directed on pak. <i>(Note: Add ribavirin to GTP 1a. Not recommended in CTP B; contraindicated in CTP C)</i>	28 day supply	<input type="checkbox"/> 12 Weeks <input type="checkbox"/> 24 Weeks <input type="checkbox"/> Other: _____
<input type="checkbox"/> Vosevi® <small>(sofosbuvir/velpatasvir/voxilaprevir)</small>	<input type="checkbox"/> 400/100/100 mg Tablet	<input type="checkbox"/> Take one tablet by mouth once daily with food. <i>(Note: Not recommended in CTP B or C)</i>	28 day supply	<input type="checkbox"/> 12 Weeks <input type="checkbox"/> Other: _____
<input type="checkbox"/> Zepatier® <small>(elbasvir/grazoprevir)</small>	<input type="checkbox"/> 50/100 mg Tablet	<input type="checkbox"/> Take one tablet by mouth once daily, with or without food. <i>(Note: Add ribavirin if appropriate. Contraindicated in CTP B or C)</i>	28 day supply	<input type="checkbox"/> 12 Weeks <input type="checkbox"/> 16 Weeks <input type="checkbox"/> Other: _____
<input type="checkbox"/> OTHER:	<input type="checkbox"/> Drug Strength:	<input type="checkbox"/> Directions:		

Deliver to: Patient Office Other: _____ Date: _____ Needs by Date: _____

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