Hepatology Enrollment Form (1 of 2)

PYRAMIDS SPECIALTY PHARMACY

www.pyramidspharmacy.com

All our referral forms are available on our website.

10970 Shadow Creek Pkwy, Suite 110.1 I Pearland, TX 77584 I Phone: 1.888.375.1920 I 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
☐ Daklinza™ (daclatasvir)	☐ 30 mg Tablet ☐ 60 mg Tablet	☐ Take one tablet by mouth once daily with sofosbuvir (Sovaldi®), with or without food. *(Note: Add ribavirin for decompensated)*	28 day supply	
☐ Epclusa® (sofosbuvir/velpatasvir)	☐ 400/100 mg Tablet	☐ Take one tablet by mouth once daily, with or without food. *(Note: Add ribavirin for decompensated)*	28 day supply	
☐ Harvoni® (ledipasvir/sofosbuvir)	☐ 90/400 mg Tablet	☐ Take one tablet by mouth once daily, with or without food. *(Note: Add ribavirin for decompensated)*	28 day supply	
☐ Mavyret™ (glecaprevir/pibrentasvir)	☐ 100/40 mg Tablet	☐ Take 3 tablets by mouth once daily with food. *(Note: Not recommended in CTP B; contraindicated in CTP C)*	28 day supply	
☐ Ribavirin	☐ 200 mg Tablet ☐ 200 mg Capsule	☐ Take _____ tablets/capsules by mouth every morning and _____ tablets/capsules every evening with food.	28 day supply	
☐ Sovaldi® (sofosbuvir)	☐ 400 mg Tablet	☐ Take one tablet by mouth once daily, with or without food. *(Note: Administered with ribavirin and/or daclatasvir)*	28 day supply	

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: _____