Sunray
Specialty Pharmacy

Hepatitis C Enrollment Form

Fax: (215) 471-4001
Phone: (215) 471-4000

PATIENT INFORMATION:

Patient's Name: _____
Address: _____
City, State, Zip Code: _____
Home Phone: _____
Alternate Phone: _____
DOB: _____
Last 4 Digits of SS#: _____
Gender: _____
Language Preference: _____

PRESCRIBER INFORMATION:

Prescriber's Name: _____
DEA: _____
NPI: _____
Address: _____
City, State, Zip Code: _____
Phone: _____
Fax: _____
Contact Person: _____
Contact Person's Phone: _____

INSURANCE INFORMATION: (please include copy of front and back of patient's prescription insurance card)

BIN: _____ PCN: _____ Rx Group: _____ ID #: _____ Prior Authorization Reference #: _____

MEDICAL INFORMATION: (may attach separate sheet if needed)

Diagnosis: Please include diagnosis **and** ICD-10 code

- ☐ B18.2 Chronic Hepatitis C
- ☐ K72.90 Hepatic failure, unspecified without coma
- ☐ C22.0 Liver Cell Carcinoma
- ☐ Other Diagnosis:
  - ICD-10 Code: _____
  - Description: _____

HIV Coinfected: ☐ Yes ☐ No
HBV Coinfected: ☐ Yes ☐ No
Genotype: _____
Viral Load: _____ IU/mL
Viral Load Date: _____

Additional information:

Weight: _____ kg/lb Height _____ cm/in
Allergies: _____
Previous therapy history: ☐ Naïve ☐ Relapsed ☐ Partial Responder ☐ None
Prior Therapies: _____
Concomitant Medications: _____
_____
Cirrhosis: ☐ Yes ☐ No ☐ Compensated or ☐ Decompensated
Fibrosis Score _____
Liver Transplant: ☐ Yes ☐ No Waiting for Liver Transplant: ☐ Yes ☐ No

Please include hard copies of genotype, viral load, liver biopsy scans, CMC, CMP, HIV, PT/INR, H&P, NSSA resistance testing, and other pertinent notes

PRESCRIPTION INFORMATION

Medication	Dose	Directions	Quantity	Refills
Daklinza®	☐ 30mg ☐ 60mg	☐ Take 1 tablet once daily		
Epclusa®	☐ 400mg/100mg	☐ Take 1 tablet once daily		
Harvoni®	☐ 90mg/400mg	☐ Take 1 tablet once daily		
Mavyret®	☐ 100mg/40mg	☐ Take 3 tablets once daily with food		
Ribavirin	☐ 1000mg/day (<75kg) ☐ 1200mg/day (≥75kg)			
RibaPak®	☐ 1200mg/day ☐ 1000mg/day ☐ 800mg/day ☐ 600mg/day	☐ 600mg qAM, 600mg qPM ☐ 600 mg qAM, 400mg qPM ☐ 400mg qAM, 400mg qPM ☐ 200mg qAM, 400mg qPM		
Sovaldi™	☐ 400mg	☐ Take 1 tablet once daily		
Viekira Pak®	☐ 12.5mg/75mg/50mg/250mg	☐ Take 2 ombitasvir/paritaprevir/ritonavir tablets qAM and 1 dasabuvir 250 mg BID with a meal		
Vosevi®	☐ 400mg/100mg/100mg	☐ Take 1 tablet once daily with food		
Zepatier®	☐ 50mg/100mg	☐ Take 1 tablet once daily with food		
Promacta®	☐ 12.5mg ☐ 25mg ☐ 50mg ☐ 75mg ☐ 100mg			
OTHER: _____				

Please deliver to: ☐ Patient ☐ Office ☐ Other _____ by this 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

Prescriber's Signature: _____