Hepatitis C Virus

TotalCareRX
SPECIALTY PHARMACY

Phone: 718-762-7111
Fax: 718-947-1079

Patient Information

Patient name: _____ DOB: _____
Sex: ☐ Female ☐ Male SSN: _____ Ethnicity: _____
Language: _____ Wt: _____ ☐ kg ☐ lbs Ht: _____ ☐ cm ☐ in
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____
Local pharmacy: _____ Phone: _____
Insurance plan: _____ Plan ID: _____
Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: _____
NPI: _____
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email: _____
If shipping to prescriber: ☐ First Fill ☐ Always ☐ Never

Clinical Information (Please fax pertinent clinical and lab information)

Diagnosis: ☐ B18.2 (Chronic Hepatitis C Virus) Diagnosis date: _____
Genotype: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Subtype: ☐A ☐B ☐A/B ☐N/A
Baseline viral load: _____ Date: _____
Degree of fibrosis: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4 ☐ _____
Cirrhosis: ☐ None ☐ Compensated ☐ Decompensated (CTP: ☐ B ☐ C)
Co-infection(s): ☐ None ☐ HIV ☐ HBV

Transplant status: ☐ N/A ☐ Pre-transplant ☐ Post-transplant
sCr: _____ GFR: _____ Date: _____
CKD stage: ☐1 ☐2 ☐3 ☐4 ☐5 ☐N/A Dialysis: ☐Yes ☐No
IL28B polymorphism: ☐CC ☐CT ☐TT
Q80K polymorphism: ☐ Yes ☐ No NS5A polymorphism: ☐ Yes ☐ No
NS5A polymorphism type: ☐M28 ☐Q30 ☐L31 ☐Y93 ☐ _____

Prior Regimen ☐ Naïve ☐ Experienced (List below)	Start Date	End Date	Treatment Weeks	Response*
				☐IC ☐ NR ☐ PR ☐ RLP
				☐IC ☐ NR ☐ PR ☐ RLP

**Response definitions: IC – Incomplete treatment, NR – Null Responder, PR – Partial Response, RLP - Relapser*

Comorbidities: _____
Concomitant Medications: _____
Allergies: ☐ NKDA ☐ Other: _____

Expected Duration of Therapy: ☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ 24 weeks

Prescription		Quantity	Refill
☐ **Epclusa®** **(velpatasvir/sofosbuvir)**	☐ Take 100 mg/400 mg by mouth once daily	☐ 28 x 100 mg/400 mg tablets	_____
☐ **Harvoni®** **(ledipasvir/sofosbuvir)**	☐ Take 90 mg/400 mg by mouth once daily	☐ 28 x 90 mg/400 mg tablets	_____
☐ **Mavyret™** **(glecaprevir + pibrentasvir)**	☐ Take 3 tablets by mouth once daily with food	☐ 84 x 100 mg/40 mg tablets	_____
☐ **Sovaldi®** **(sofosbuvir)**	☐ Take 400 mg by mouth once daily	☐ 28 x 400 mg tablets	_____
☐ **Vosevi™** ☐ **(sofosbuvir/velpatasvir/voxilaprevir)**	☐ Take 1 tablet by mouth once daily with food	☐ 28 x 400 mg/100 mg/100 mg tablets	_____

***For the form (tablets or capsules), unless otherwise specified, pharmacy preference/availiability (or insurance preference) will be dispensed.*

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Prescriber's Signature: _____ Date: _____

I authorize Total Care Rx, Inc. and its representatives to act as an agent to initiate and execute the insurance prior authorization and appeal process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Total Care Rx, Inc.

Reset Form