



**Hepatitis C Enrollment Form**  
**Physician Offices Call: 855-460-7928**  
**Fax: 888-777-5645**

<b>Prescriber:</b>	<b>NPI:</b>
<b>Supervising Physician:</b>	<b>NPI:</b>
<b>Address:</b>	<b>Tax ID:</b>
<b>Phone:</b>	<b>Fax:</b>
<b>Contact:</b>	

*This prescription form is to be sent & received via fax*

**PATIENT INFORMATION**

<b>Name:</b>	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Trans M <input type="checkbox"/> Trans F <input type="checkbox"/> Other	<b>DOB:</b> ____/____/____	<b>SS#:</b> ____-____-____
<b>Street:</b>	<b>City:</b>	<b>State:</b>	<b>ZIP:</b>
<b>Phone:</b>	<b>Alt. Phone:</b>	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:	<b>Wt.:</b> <b>Ht.:</b>

**PRESCRIPTION**

<input type="checkbox"/> <b>New</b> <input type="checkbox"/> <b>Refill</b>	<b>Ship by:</b> ____/____/____	<b>Ship to:</b> <input type="checkbox"/> Patient's Home <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Other: _____	
<b>Drug</b>	<b>Strength</b>	<b>Directions &amp; Quantity</b>	<b>Refills</b>
<b>Epclusa®</b> <small>(sofosbuvir/velpatasvir)</small>	<input type="checkbox"/> 400/100 mg Tablet	<input type="checkbox"/> Take one tablet PO QD with or without food (Quantity: 28)	
<b>Harvoni®</b> <small>(ledipasvir/sofosbuvir)</small>	<input type="checkbox"/> 90/400 mg Tablet	<input type="checkbox"/> Take one tablet PO QD with or without food (Quantity: 28)	
<b>Mavyret®</b>	<input type="checkbox"/> 100/40 mg Tablet	<input type="checkbox"/> Take three tablets PO QD with food (Quantity: 84)	
<b>Sovaldi®</b>	<input type="checkbox"/> 400 mg Tablet	<input type="checkbox"/> Take one tablet PO QD with or without food (Quantity: 28)	
<b>Vosevi®</b>	<input type="checkbox"/> 400/100/100 mg Tablet	<input type="checkbox"/> Take one tablet PO QD with food (Quantity: 28)	

**RIBAVIRIN PRODUCTS**

<b>Directions &amp; Quantity</b>	<input type="checkbox"/> Ribavirin Tablet	<input type="checkbox"/> Ribavirin Capsule
<input type="checkbox"/> Take ____mg QAM, ____mg QPM (Quantity: ____)		

**MEDICAL INFORMATION**

**\*\*\*PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES & LAB WORK REGARDING THERAPY\*\*\***

<b>Diagnosis:</b> <input type="checkbox"/> B18.2 Chronic Hepatitis C Virus (HCV)	<b>Date of Diagnosis:</b> ____/____/____	<b>Treatment Naïve?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Genotype:</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	<b>Subtype:</b> <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> A/B <input type="checkbox"/> N/A	<b>Baseline viral load:</b> _____ IU/mL <b>Date:</b> ____/____/____
<b>Cirrhosis:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, is it: <input type="checkbox"/> compensated <input type="checkbox"/> decompensated)	<b>Co-infection status:</b> <input type="checkbox"/> HIV <input type="checkbox"/> HBV <input type="checkbox"/> N/A	
<b>Degree of liver fibrosis:</b> <input type="checkbox"/> F0 <input type="checkbox"/> F1 <input type="checkbox"/> F2 <input type="checkbox"/> F3 <input type="checkbox"/> F4	<b>Polymorphism(s):</b> <input type="checkbox"/> NS5A <input type="checkbox"/> IL28B <input type="checkbox"/> Q80K <input type="checkbox"/> N/A	
<b>Prior HCV Treatment:</b>	<b>Date(s) of treatment:</b>	<b>Treatment weeks:</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
		<b>Treatment Response:</b>
		<input type="checkbox"/> Incomplete <input type="checkbox"/> Null <input type="checkbox"/> Partial <input type="checkbox"/> Relapsed
		<input type="checkbox"/> Incomplete <input type="checkbox"/> Null <input type="checkbox"/> Partial <input type="checkbox"/> Relapsed
		<input type="checkbox"/> Incomplete <input type="checkbox"/> Null <input type="checkbox"/> Partial <input type="checkbox"/> Relapsed

<b>Allergies:</b> _____	<b>Expected Duration of Therapy:</b> <input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> 16 weeks <input type="checkbox"/> 24 weeks
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**Additional Clinical Information:**

  
  
  
  
  
  
  
  
  
  

**PRESCRIBER SIGNATURE REQUIRED---STAMPED SIGNATURE NOT ALLOWED**

**To Prescriber:** By signing this form and utilizing our services, you are also authorizing Senderra to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

<b>PRODUCT SUBSTITUTION PERMITTED</b>	<b>DISPENSE AS WRITTEN</b>
X _____ <b>Date:</b> ____/____/____	X _____ <b>Date:</b> ____/____/____

**CONFIDENTIALITY NOTICE**

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