Faxed prescriptions will only be accepted from a prescriber. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Senderra.

SENDERRA
Specialty Pharmacy
3712 E. Plano Parkway, Ste. 200
Plano, TX 75074
This prescription form is to be sent & received via fax

Hepatitis C Enrollment Form

Physician Offices Call: 855-460-7928

Fax: 888-777-5645

Prescriber:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Phone:	Fax:
Contact:	

PATIENT INFORMATION

Name:	☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other	DOB: ____/____/_____	SS#: ____-____-_____
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	☐ English ☐ Spanish ☐ Other: _____	Wt.: Ht.:

PRESCRIPTION

☐ **New** ☐ **Refill** **Ship by:** ____/____/_____ **Ship to:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other:** _____

Drug	Strength	Directions & Quantity	Refills
Epclusa® (*sofosbuvir/velpatasvir*)	☐ 400/100 mg Tablet	☐ Take one tablet PO QD with or without food (Quantity: 28)	
Harvoni® (*ledipasvir/sofosbuvir*)	☐ 90/400 mg Tablet	☐ Take one tablet PO QD with or without food (Quantity: 28)	
Mavyret®	☐ 100/40 mg Tablet	☐ Take three tablets PO QD with food (Quantity: 84)	
Sovaldi®	☐ 400 mg Tablet	☐ Take one tablet PO QD with or without food (Quantity: 28)	
Viekira Pak®	☐ 12.5/75/50 mg Tablet	☐ Take two pink tablets PO QD (morning) and one beige tablet PO BID (morning and evening) with a meal (Quantity: 56/56)	
Vosevi®	☐ 400/100/100 mg Tablet	☐ Take one tablet PO QD with food (Quantity: 28)	
Zepatier®	☐ 50/100 mg Tablet	☐ Take one tablet PO QD with or without food (Quantity: 28)	

RIBAVIRIN PRODUCTS

Directions & Quantity			
☐ Take____mg QAM, ____mg QPM (Quantity: ____)	☐ **Ribavirin Tablet**	☐ **Ribavirin Capsule**	

MEDICAL INFORMATION

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

Diagnosis: ☐ B18.2 Chronic Hepatitis C Virus (HCV) Date of Diagnosis: ____/____/_____	**Treatment Naïve?** ☐ Yes ☐ No
Genotype: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 **Subtype:** ☐ A ☐ B ☐ A/B ☐ N/A	**Baseline viral load:** _____ **IU/mL Date:** ____/____/_____
Cirrhosis: ☐ Yes ☐ No (if yes, is it: ☐ compensated ☐ decompensated)	**Co-infection status:** ☐ HIV ☐ HBV ☐ N/A
Degree of liver fibrosis: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4	**Polymorphism(s):** ☐ NS5A ☐ IL28B ☐ Q80K ☐ N/A

Prior HCV Treatment:	Date(s) of treatment:	Treatment weeks:	Treatment Response:
_____	_____	_____	☐ Incomplete ☐ Null ☐ Partial ☐ Relapsed
_____	_____	_____	☐ Incomplete ☐ Null ☐ Partial ☐ Relapsed
_____	_____	_____	☐ Incomplete ☐ Null ☐ Partial ☐ Relapsed

Allergies: _____ **Expected Duration of Therapy:** ☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ 24 weeks

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.

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

CONFIDENTIALITY NOTICE