USspecialty
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HEPATITIS C ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 **FAX:** 800-530-8589 **WEB:** www.usspecialtycare.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

PATIENT INFORMATION

Patient:______________________________ Caregiver: ______________________

DOB:_________ ☐ Male ☐ Female Weight:______ ☐ kgs or ☐ lbs (check one) Height______ ☐ in or ☐ cm (check one) Recorded Date: ____________

Address:______________________________ City: ______________________ State: ______ Zip: ____________

Best Phone #:_______________________ ☐ Cell Alternate Phone #:_______________________ ☐ Cell Email:_______________________

Allergies:______________________________ Latex Allergy: ☐ Yes ☐ No

ICD-10 Code for requested therapy: ______________________ ICD-10 Code(s) for other medical conditions:

MEDICAL ASSESSMENT

PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION

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)

☐ Treatment Naïve ☐ Treatment Experienced

☐ Prior treatment (list):_____________________________________
____
____
____
____

☐ Failed therapy (list): _____________________________________
____
____
____

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 ☐ ______

PLEASE PROVIDE ALL CLINICAL INFORMATION INCLUDING LAB RESULTS ON ALL FORMS

PRESCRIPTION INFORMATION

Medication	Strength	Directions	Quantity	Refills
Epclusa® (sofosbuvir/velpatasvir)	☐ 400 mg sofosbuvir/100 mg velpalasvir per tablet	Take one tablet once daily with or without food.	28 day supply	Total Therapy: ☐ 12 weeks
Harvoni® (ledipasvir/sofosbuvir)	☐ 90 mg ledipasvir/ 400 mg sofosbuvir per tablet ☐ 45/200 (only for brand name)	Take orally once daily with or without food. Do not take within 4 hours of antacids.	28 day supply	Total Therapy: ☐ 8 weeks ☐ 12 weeks ☐ 24 weeks
Lepidasvir/Sofosbuvir (generic for Harvoni)	90/400	Take one tablet once daily with or without food.	28 day supply	Total Therapy: ☐ 8 weeks ☐ 12 weeks ☐ 24 weeks
Mavyret (Glecaprevir/Pibrentasvir)	100/40	3 tablets one time daily with food	28 day supply	Total Therapy: ☐ 8 weeks ☐ 12 weeks
Ribavirin/Ribasphere®	☐ 200 mg tablets ☐ 200mg capsules ☐ 200 mg tablets ☐ 400 mg tablets ☐ 600 mg tablets	Take ________ tabs/caps orally q am and ______ tabs/caps q pm for a total of ________ mg daily		
Ribasphere® RibaPak®	☐ 600/600 mg ☐ 600/400 mg ☐ 400/400 mg ☐ 200/400 mg	Take ________ mg orally q am and ________ q pm for a total of _________ mg daily		

PRESCRIPTION INFORMATION

Medication	Strength	Directions	Quantity	Refills
Sofosbuvir/Velpatasvir (generic for Eplcusa)	400/100	1 tablet daily with or without food.	28 day supply	Total Therapy: ☐ 12 weeks
Solvaldi® (sofosbuvir)	400 mg tablets	Take one 400 mg tablet orally once a day with or without food	28 day supply	
Viekira Pak™ (Dasabuvir Oral tablet/ Ombitasvir/Paritaprevir/ Ritonavir)	250mg Dasabuvir/ 12.5mg Ombitasvir/ 75mg Paritaprevir/50mg Ritonavir	Take 2 pink tablets (ombitasvir, paritaprevir, ritonavir) once daily (morning) and 1 beige tablet (dasbuvir) twice daily (morning and evening) with meals.	28 day supply	Total Therapy: ☐ 12 weeks ☐ 24 weeks
Vosevi (Sofosbuvir/Velpatasvir/ Voxilaprevir)	400/100/100	1 tablet daily with food. Do not take within 4 hours of antacids containing Al mg	28 day supply	Total Therapy: ☐ 12 weeks
Zepatier™ (elbasvir/grazoprevir)	☐ 50 mg elbasvir/100 mg grazoprevir per tablet	Take one tablet daily with or without food	28 day supply	Total Therapy: ☐ 12 weeks ☐ 16 weeks
Other:				

INJECTION TRAINING: ☐ **OFFICE TO COORDINATE** ☐ **USSC TO COORDINATE**

PRESCRIBER INFORMATION

Anticipated Start Date: ______________________________ Prescriber Specialty: ______________________________

Ship to: ☐ Patient ☐ Physician ☐ Clinic ☐ Other:______________________________

Fax #: ______________________________Contact Name: ______________________________

Office Address: ______________________________ City: ______________________________ State: _____ Zip: ________

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☐ I understand that USSC may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.

Prescriber's Name: ______________________________Prescriber's Signature: ______________________________Date: __________

☐ Use substitution ☐ Dispense as Written

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