HEPATITIS C **ENROLLMENT FORM**

PLEASE FAX: FOURTH STREET - 302-502-3885 • MARKET STREET - 302-513-9396

GREENHILL PLUS
Specialty Pharmacy Solution
Connection • Care • Community
Greenhill Pharmacy | 2511 W 4th St, Wilmington, DE 19805

Patient Information

Patient Name _____
Address _____
Apt/Suite _____ City _____
State _____ Zip _____
Home Phone _____ Alternate Phone _____
DOB _____ SSN _____ Gender ○ M ○ F
Weight _____ kg/lbs Height _____ cm/in
Language Preference: ○ English ○ Spanish ○ Other _____
Please fax a copy of front and back of the insurance card(s)

Prescriber Information

Prescriber's Name _____
DEA _____
NPI _____
Group/Hospital _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____
Contact Person _____ Phone _____

Medical Information (Section must be completed to process prescription) Attach separate sheets as needed

○ B18.2 Chronic Hepatitis C ○ K72.90 Hepatic failure, unspecified without coma ○ C22.0 Liver Cell Carcinoma
○ Other Diagnosis: ICD-10 Code _____ Description _____
Genotype _____ Viral Load _____ IU/ml Viral Load Date _____ HIV Coinfected: ○ Yes ○ No HBV Coinfected: ○ Yes ○ No
Previous therapy history: Naïve _____ Relapsed _____ Partial Responder _____ Null _____
Date(s) of previous therapy and medication _____
Cirrhosis: ○ Yes ○ No Compensated Liver Disease: ○ Yes ○ No Fibrosis Score _____
Liver Transplant: ○ Yes ○ No Waiting for Liver Transplant: ○ Yes ○ No
Please include hard copies of: genotype, viral load, liver biopsy scans, CBC, CMP, HIV, PT / INR, H&P, NS5A resistance testing and pertinent office visit notes.

Prescription Information

Ship Medications: ○ Patient's Home ○ Phyician's Office

Drugs	Direction	Quantity	Refills
Daklinza® ○ 30mg ○ 60mg (daclatasvir)	○ Disp. 28 Sig: One tablet daily with or without food Total duration of therapy _____ Weeks		
Epclusa (sofosbuvir 400mg velpatasvir 100mg)	○ Disp. 28 Sig: 1 tablet daily Total duration of therapy _____ Weeks		
Harvoni® (ledipasvir 90mg sofosbuvir 400mg)	○ Disp. 28 Sig: 1 tablet daily Total duration of therapy _____ Weeks		
Ribavirin 200mg	○ < 75 kg = 1000 mg / day ○ ≥ 75 kg = 1200 mg / day Total duration of therapy _____ Weeks		
Ribapak (28 day supply)	○ 1200mg daily / 600mg QAM — 600mg QPM ○ 1000mg daily / 600mg QAM — 400mg QPM ○ 800mg daily / 400mg QAM — 400mg QPM ○ 600mg daily / 200mg QAM — 400mg QPM (Total duration of therapy _____ Weeks		
Moderiba (28 day supply)	○ 1200mg daily / 600mg QAM — 600mg QPM ○ 1000mg daily / 600mg QAM — 400mg QPM ○ 800mg daily / 400mg QAM — 400mg QPM ○ 600mg daily / 200mg QAM — 400mg QPM (Total duration of therapy _____ Weeks		
Mavyret (100/400 mg)	○ Disp. 84 Sig: 3 tablets PO daily with food (Total duration of therapy _____ Weeks		
Vosevi (400/100/100 mg)	○ Disp. 28 Sig: 1 tablet PO daily (Total duration of therapy _____ Weeks		

Drugs	Direction	Quantity	Refills
Sovaldi™ (sofosbuvir)	○ Disp. 28 Sig: 400mg daily Total duration of therapy _____ Weeks		
Technivie™	○ Disp. 28 day supply Sig: Take 2 tablets once daily (in am) with food. Total duration of therapy _____ Weeks		
Viekira XR	○ Disp. 84 tabs (28 day supply) Sig: Take 3 tablets by mouth once daily. Total duration of therapy _____ Weeks		
Viekira PAK	○ Disp. 28 day supply Sig: Take 2 ombitasvir, paritaprevir, ritonavir 12.5mg / 75mg / 50mg tablets once daily (in am) and 1 dasabuvir 250mg tablet twice daily (am & pm) with a meal. Total duration of therapy _____ Weeks		
Zepatier (elbasvir 50mg / grazoprevir 100mg)	○ Disp. 28 Sig: Take 1 tablet daily with or without food. ○ NS5A resistance testing included Total duration of therapy _____ Weeks		
PROMACTA* PO QD *Titrate based on platelet count not to exceed 100mg PO QD	○ 12.5mg tablets ○ 25mg tablets ○ 50mg tablets ○ 75mg tablets ○ 100mg tablets		

Ship to: ○ ***Patient*** ○ ***Office*** ○ ***Other*** _____ ***Date*** _____ ***Needs by 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.

Prescriber's Signature: _____ _____ ***Date:*** _____
PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

Supervising Physician / Supervising Physician Signature: _____

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NEW REFERRAL CHECKLIST
PLEASE USE THIS CHECKLIST FOR HEPATITIS C PATIENTS

Please use the attached checklist as a reference in order to provide the proper documentation to process the required prior authorization for your patient's treatment. All lab reports (or EMR) must contain the following information within the last 30 days. ***Please forward to us any updates you receive from the insurance company regarding approvals or denials.***

REQUIRED INFORMATION:

- ○ Patient Name
- ○ Patient Demographics (Address, Phone Number, DOB, etc.)
- ○ Medication list and allergies
- ○ Insurance information with prescription insurance. Please include a copy of card.
  If only medical insurance card is provided, please include local pharmacy information.
- ○ MD Name/NPI/Office Contact/Phone Number
- ○ Drug indicated with refills and planned treatment duration
- ○ MD signature and date on referral form

CLINICAL INFORMATION: PREFERABLY, LABS AND TEST RESULTS SHOULD BE WITHIN 8-12 WEEKS OF THE DATE ON THE REFERRAL:

- ○ Patient weight
- ○ Genotype (hard copy from lab)
- ○ HCV RNA (Viral load)
- ○ Lab results with CBC, ALT/AST, HGB, INR, HFP AND GFR
- ○ Liver biopsy/Metavir/FibroSure lab
  (Most plans are still requiring stage 2 – 4 fibrosis, but others simply need to see some form of test)
- ○ Has patient ever had a liver transplant?
- ○ Is the patient co-infected HIV/Hep C?
- ○ Previous treatment with medications, dates, and outcome
- ○ Drug/alcohol test (if applicable)

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