RELIANT HEALTHCARE

Hepatitis C
ORDER FORM

Phone: (877) 354-2688
Fax: (844) 635-5250

PATIENT INFORMATION

Name:
Address:
City: **State:** **ZIP:**
Phone: **Alt Phone:**
Email: **Caregiver:**
DOB: **Ht:** **Wt:** **Gender:** ☐ M ☐ F

PRESCRIBER INFORMATION

Name:
Address:
City: **State:** **ZIP:**
Phone: **Fax:**
NPI: **DEA:** **Tax ID:**
Office Contact: **Phone:**

CLINICAL INFORMATION

Diagnosis (ICD-10): ☐ B18.2 Chronic hepatitis C ☐ B17.10 Acute hepatitis C ☐ Z94.4 Liver transplant ☐ B20 HIV
☐ Hepatitis B, ICD-10: ☐ Other:

Drug Allergies: **Latex Allergy:** ☐ Yes ☐ No

Genotype: ☐ 1a (+/- NS5A RAVs) ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

Responder Status: ☐ Naive ☐ Relapsed ☐ Partial responder ☐ Non-responder

Fibrosis Stage: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4 **Viral Load:** **Load Date:**
☐ Cirrhosis ☐ Decompensated ☐ Liver transplant candidate ☐ Solid organ transplant recipient

Prior HCV Therapy: **Length of Treatment:** **Reason for Discontinuing:**
Prior HCV Therapy: **Length of Treatment:** **Reason for Discontinuing:**

Please Fax Copies: ☐ Medical card (front and back) ☐ Prescription card (front and back) ☐ Clinical notes

MEDICATION	DOSAGE AND STRENGTH	DIRECTIONS ☐ SHIP TO HOME ☐ IN OFFICE	QTY	REFILLS
☐ **Epclusa** *sofosbuvir/velpatasvir*	☐ 400mg/100mg Tablet	☐ Take 1 tablet PO daily with or without food Duration: ☐ 12 weeks ☐ 24 weeks ☐ Other: weeks	QS	
☐ **Harvoni** *ledipasvir/sofosbuvir*	☐ 90mg/400mg Tablet	☐ Take 1 tablet PO daily with or without food Duration: ☐ 8 weeks ☐ 12 weeks ☐ 24 weeks ☐ Other: weeks	QS	
☐ **Mavyret** *glecaprevir/pibrentasvir*	☐ 100mg/40mg Tablet	☐ Take 3 tablets PO daily with food Duration: ☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ Other: weeks	QS	
☐ **Ribavirin**	☐ 200mg Tablets ☐ 200mg Capsules	☐ **1400mg/day:** Take 600mg PO every AM and 800mg PO every PM ☐ **1200mg/day:** Take 600mg PO every AM and 600mg PO every PM ☐ **1000mg/day:** Take 400mg PO every AM and 600mg PO every PM ☐ **800mg/day:** Take 400mg PO every AM and 400mg PO every PM ☐ Other: mg PO every AM and mg PO every PM Duration: ☐ 12 weeks ☐ 24 weeks ☐ Other: weeks	QS QS QS QS	
☐ **Sovaldi** *sofosbuvir*	☐ 400mg Tablet	☐ Take 1 tablet PO daily with or without food Duration: ☐ 12 weeks ☐ 24 weeks ☐ Other: weeks	QS	
☐ **Vosevi** *sofosbuvir/velpatasvir/voxilaprevir*	☐ 400mg/100mg/100mg Tablet	☐ Take 1 tablet PO daily with food Duration: ☐ 12 weeks ☐ Other: weeks	QS	
☐ **Zepatier** *elbasvir/grazoprevir*	☐ 50mg/100mg Tablet	☐ Take 1 tablet PO daily with or without food Duration: ☐ 12 weeks ☐ 16 weeks ☐ Other: weeks	QS	
☐ **Other**		Directions:		

By signing, I authorize Reliant Healthcare and its employees to act as my prior authorization designated agent with medical and prescription insurers and patient assistance programs, and to substitute an approved biosimilar if required or allowed by insurance coverage. I certify that the person named is my patient, the information provided is complete and accurate to the best of my knowledge, and the therapy is medically necessary.

Physician Name (Print) Physician Signature Date