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HEPATITIS ASSIST[®] ENROLLMENT FORM

Today's Date: _____
 Needed By: _____

Last update 10.31.2018



www.commcarepharmacy.com
 Plantation, FL
 Phone: 888.203.7973
 Fax: 888.203.7980
 NCPDP: 1079638
 NPI: 1598762015

Patient Demographics: (Please provide the following or attach demographics sheet)
 Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Preferred Phone: _____ Alt. Phone: _____
 Last four digits of SS#: _____ Date of Birth: _____
 Gender: _____ Allergies: _____ Height: _____ Weight: _____

Provider Office: (Please provide as much information as possible)
 Prescriber's Name: _____ Group/Hospital: _____
 Specialty: _____ License#: _____ Tax ID#: _____
 Address: _____
 NPI: _____ DEA: _____
 City, State, Zip: _____
 Phone: _____ Fax: _____ Office Contact: _____

Insurance Information: (Please copy and attach the front and back of the patient's insurance card)

Medication Delivery to: (choose one) Patient's Address Always to Physician's Office First fill to Physician's Office, refills to Patient's Address

Diagnostic Information: Diagnosis (ICD-10-CM codes) B18.2 Chronic Hepatitis C Other _____ Other _____

Clinical Information:
 HCV Genotype: 1 2 3 4 5 6 Subtype: _____
 Viral Load: _____ Viral Load Date: _____
 Is patient: Treatment Naïve Partial Responder Relapser Non-Responder
 Previous therapy and dates (if applicable): _____
 History of liver biopsy: Yes No N/A Fibrosis Level: F0 F1 F2 F3 F4
 Fibrosan: _____ or Metavir: _____ Cirrhosis: None Compensated Decompensated
 Q80K polymorphism: None Yes NS5A resistance-associated polymorphism: None Yes

Additional Clinical Information:
 Is patient pregnant? Yes No
 HIV Co-infected? Yes No
 HBV Co-infected? Yes No
Transplant:
 Pre-transplant Post-transplant
 Other Medical Conditions: _____

Drug Name	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Daklinza [®] (daclatasvir)	<input type="checkbox"/> 30mg <input type="checkbox"/> 60mg <input type="checkbox"/> 90mg	<input type="checkbox"/> 1 Tablet PO ONCE Daily	4 Week Supply	
<input type="checkbox"/> Epclusa [®] (velpatasvir/sofosbuvir)	<input type="checkbox"/> 100mg velpatasvir/400mg sofosbuvir	<input type="checkbox"/> 1 Tablet PO ONCE Daily	4 Week Supply	
<input type="checkbox"/> Harvoni [®] (ledipasvir/sofosbuvir)	<input type="checkbox"/> 90mg ledipasvir/400mg sofosbuvir	<input type="checkbox"/> 1 Tablet PO ONCE Daily	4 Week Supply	
<input type="checkbox"/> Mavyret [™] (glecaprevir/pibrentasvir)	<input type="checkbox"/> 100mg glecaprevir/40mg pibrentasvir	<input type="checkbox"/> 3 Tablets PO ONCE Daily	4 Week Supply	
<input type="checkbox"/> Sovaldi [®] (sofosbuvir)	<input type="checkbox"/> 400mg	<input type="checkbox"/> 1 Tablet PO ONCE Daily	4 Week Supply	
<input type="checkbox"/> Viekira Pak [®] (ombitasvir/paritaprevir/ritonavir; dasabuvir)	<input type="checkbox"/> 12.5mg ombitasvir/75mg paritaprevir/50mg ritonavir; 250mg dasabuvir	<input type="checkbox"/> 2 ombitasvir/paritaprevir/ ritonavir tablets PO ONCE Daily and 1 dasabuvir tablet TWICE Daily	4 Week Supply	
<input type="checkbox"/> Vosevi [™] (sofosbuvir/velpatasvir/voxilaprevir)	<input type="checkbox"/> 400mg sofosbuvir/100mg velpatasvir/100mg voxilaprevir	<input type="checkbox"/> 1 Tablet PO ONCE Daily	4 Week Supply	
<input type="checkbox"/> Zepatier [®] (elbasvir/grazoprevir)	<input type="checkbox"/> 50mg elbasvir/100mg grazoprevir	<input type="checkbox"/> 1 Tablet PO ONCE Daily	4 Week Supply	

Ribavirin Products

<input type="checkbox"/> Moderiba [™] (ribavirin)	<input type="checkbox"/> 200-400mg <input type="checkbox"/> 400-400mg <input type="checkbox"/> 400-600mg <input type="checkbox"/> 600- 600mg	<input type="checkbox"/> 1 Tablet PO TWICE Daily	4 Week Supply	
<input type="checkbox"/> RibaPak [®] (ribavirin)	<input type="checkbox"/> 200-400mg <input type="checkbox"/> 400-400mg <input type="checkbox"/> 400-600mg <input type="checkbox"/> 600- 600mg	<input type="checkbox"/> 1 Tablet PO TWICE Daily	4 Week Supply	
<input type="checkbox"/> Ribavirin	<input type="checkbox"/> 200 Capsules <input type="checkbox"/> 200 Tablets	<input type="checkbox"/> Please Specify:	4 Week Supply	

Other Products

Other: _____ PO = Oral

Please specify intended duration of therapy: 8 weeks 12 weeks 24 weeks Other: _____

Unless otherwise noted this prescription authorizes Acro and Commcare to dispense & share information between each other to optimize care delivery. Check here to restrict to Acro Commcare

Physician Signature: _____ DAW (Dispense as Written) **Date:** _____

Patient Support Programs: I authorize Acro Pharmaceutical Services and Commcare Specialty Pharmacy to enroll me in company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis or other commercial purposes, and provide educational information regarding therapies. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with same effectiveness as an original. Ancillary supplies provided as needed for administration.

***Patient Signature:** (required for participation): _____ Date: _____ Please select if you would like the patient enrolled in a Manufacturer's Assistance Program
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