ACRO PHARMACEUTICAL SERVICES
A PREMIER INC. COMPANY

www.acropharmacy.com

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HEPATITISASSIST®
ENROLLMENT FORM

Today's Date:_____
Needed By:_____

Last update 10.31.2018

COMMCARE SPECIALTY PHARMACY
A PREMIER INC. COMPANY

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
Fibroscan:_____ 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
□Daklinza® (daclatasvir)	□30mg □60mg □90mg	□1 Tablet PO ONCE Daily	4 Week Supply	
□Epclusa® (velpatasvir/sofosbuvir)	□100mg velpatasvir/400mg sofosbuvir	□1 Tablet PO ONCE Daily	4 Week Supply	
□Harvoni® (ledipasvir/sofosbuvir)	□90mg ledipasvir/400mg sofosbuvir	□1 Tablet PO ONCE Daily	4 Week Supply	
□Mavyret™ (glecaprevir/pibrentasvir)	□100mg glecaprevir/40mg pibrentasvir	□3 Tablets PO ONCE Daily	4 Week Supply	
□Sovaldi® (sofosbuvir)	□400mg	□1 Tablet PO ONCE Daily	4 Week Supply	
□Viekira Pak® (ombitasvir/paritaprevir/ritonavir; dasabuvir)	□12.5mg ombitasvir/75mg paritaprevir/50mg ritonavir; 250mg dasabuvir)	□2 ombitasvir/paritaprevir/ ritonavir tablets PO ONCE Daily and 1 dasabuvir tablet TWICE Daily	4 Week Supply	
□Vosevi™ (sofosbuvir/velpatasvir/voxilaprevir)	□400mg sofosbuvir/100mg velpatasvir/100mg voxilaprevir	□1 Tablet PO ONCE Daily	4 Week Supply	
□Zepatier® (elbasvir/grazoprevir)	□50mg elbasvir/100mg grazoprevir	□1 Tablet PO ONCE Daily	4 Week Supply	
Ribavirin Products				
□Moderiba™ (ribavirin)	□200-400mg □400-400mg □400-600mg □600-600mg	□1 Tablet PO TWICE Daily	4 Week Supply	
□RibaPak® (ribavirin)	□200-400mg □400-400mg □400-600mg □600-600mg	□1 Tablet PO TWICE Daily	4 Week Supply	
□Ribavirin	□200 Capsules □200 Tablets	□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