Hepatitis C

Enrollment Form

SKYEMED PHARMACY & INFUSION SERVICES

Phone: 866-778-8255
Fax: 800-432-6614
intake@skyemed.com

Deliver Medications To: ☐ Patient's Home ☐ Doctors Office ☐ Skyemed to Train Date Needed By:_____

Patient Demographics:

Last Name: First Name: Date of Birth:

Street Address: City: State: Zip:

Home Phone: Cell Phone: SSN:

Prescription Insurance: (PLEASE ATTACH A COPY OF THE FRONT AND BACK OF THE PATIENT'S CARD)

Primary Prescription Insurance: _____ RX BIN #: _____ RX PCN#: _____

Patient ID/Policy Number: _____ Patient RX Group Number: _____

Secondary Insurance: _____ ID: BIN: PCN: Phone:

Patient Clinical Information/History: (Please attach a copy of patient's recent chart notes, pathology and labs)

Diagnosis:_____ ICD10 Code:_____ Diagnosis Date:_____ HCV Genotype:_____ Height:_____ Weight (lbs):_____

Pt Treatment History: ☐ Naive ☐ Partial Responder ☐ Relapser ☐ Nullresponder Previous Regimen and Date: _____

Baseline HCV RNA (IU/mL): _____ Date: _____ Sex: M F Pregnant or Nursing: Y N

Biopsy/CT Results: _____ Date: _____ IL-28B: _____ *Q80K Mutation: Pos Neg

Cirrhotic: Yes No HIV Coinfection: Yes No Pre-Transplant: Yes No Post-Transplant: Yes No

Interferon Ineligible: Yes No Explanation: _____

Drug Allergies: _____

Other Health Conditions: _____

Concomitant Medications: _____

Prescription Information:

☐ **Harvoni 90mg/400mg Tablet**

Take 1 tablet PO Daily

Quantity: 28 Refills:_____

☐ **Sovaldi 400 mg Tablet**

Take 1 tablet PO Daily

Quantity: 28 Refills: _____

☐ **Epclusa 400mg/100mg Tablet**

Take 1 tablet PO Daily

Quantity: 28 Refills: _____

☐ **Ribapak** ☐ **Moderiba**

☐ 400/200 Take 1 tablet PO BID
☐ 400/400 Take 1 tablet PO BID
☐ 600/400 Take 1 tablet PO BID
☐ 600/600 Take 1 tablet PO BID

Quantity: 56 Refills: _____

Ribavirin ☐ 200mg Tablet ☐ 200mg Capsule

☐ Take ___ PO QAM and ___ PO QPM

☐ Other: _____

Quantity: _____ Refills:_____

Daklinza ☐ 30MG Tablets ☐ 60MG Tablets

Take ___ tablet(s) PO Daily

Quantity:_____ Refills: _____

☐ **Technivie**

Take 2 tablets PO Once daily in the morning with a meal

Quantity:_____ Refills: _____

☐ **Viekira Pak**

Take as directed with a meal

Quantity: 112 Refills:_____

☐ **Zepatier 50mg/100mg Tablets**

Take 1 tablet PO Daily

It is recommended that genotype 1a patients undergo NS5A resistance testing prior to initiation of treatment.

Quantity: 28 Refills:_____

Prescriber Information:

Prescriber Name: Facility Group or Hospital:

Street Address: City: State: Zip:

Office Phone: **Office Fax:** **Office Contact:**

DEA: NPI: TAXID: State License:

Physician Signature: _____ **Date:** _____

***If Physician requests Brand Name Only, "Brand Medically Necessary" Must be handwritten below:**