Ph: 877.227.3405 • Fax: 877.542.2731 • E-Prescribe NPI # 1659380772 or NCPDP # 3306986

CareMed SPECIALTY PHARMACY

Hepatitis Prescription Form

PATIENT INFORMATION You may also fax demographics/face sheet

Patient Name:_____DOB: _____
SSN: _____
Address: _____
City, State, Zip: _____
Home Phone: _____Cell Phone: _____
Known Allergies: _____
Height: _____ Weight: _____lbs. ☐ M ☐ F
Emergency Contact: _____
Emergency Contact Phone: _____

INSURANCE INFO. Please fax copy of ALL insurance cards *front & back

Primary Insurance: _____
City, State: _____
ID Number: _____
Group Number: _____ Rx Bin: _____
Secondary Insurance: _____
City, State: _____
ID Number: _____
Group Number: _____ Rx Bin: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ License: _____ DEA: _____
Address: _____ City, State, Zip: _____
Office Contact: _____ Phone: _____ Fax: _____

DIAGNOSIS INFORMATION Please fax recent labs, clinical notes, etc. to help expedite the prior authorization process

☐ Hepatitis B ☐ Hepatitis C ☐ Other: _____
☐ ICD-10: _____
Prior Failed Therapies: _____ Reason For Discontinuation:_____

HEP C MEDICATIONS: You may tape Prescriptions here prior to faxing

MEDICATION	DOSE/STRENGTH	SIG	QTY	REFILLS
☐**Epclusa®**	☐ 200/50 mg tablet ☐ 400/100 mg tablet ☐ 200/50 mg packet ☐ 150/37.5 mg packet	☐ Take 1 tablet orally once a day Duration: ☐ 12 weeks ☐ **Other:**_____ ☐ **Other:**_____		
☐**Harvoni®**	☐ 33.75/150 mg packet ☐ 45/200 mg packet ☐ 45/200 mg tablet ☐ 90/400 mg tablet	☐ Take 1 tablet orally once a day ☐ One packet once a day as directed Duration: ☐ 8 weeks ☐ 12 weeks ☐ 24 weeks ☐ **Other:**_____ ☐ **Other:**_____		
☐**Mavyret®**	☐ 100/40 glecaprevir/pibrentasvir tablet ☐ 50/20 glecaprevir/pibrentasvir packet	☐ Take 3 tablets orally once a day with food Duration: ☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ **Other:**_____		
☐**Ribavirin**	☐ 200 mg tablet ☐ 200 mg capsule ☐ 40 mg/mL solution	☐ Take ____ tabs/caps orally QAM and ___ tabs/caps orally QPM with food. ☐ Take ____ mL orally QAM and ___ mL orally QPM with food. ☐ **Other:**_____		
☐**Sovaldi®**	☐ 400 mg tablet ☐ 200 mg tablet ☐ 150 mg packet ☐ 200 mg packet	☐ Take 1 tablet orally once a day Duration: ☐ 12 weeks ☐ 24 weeks ☐ **Other:**_____ ☐ **Other:**_____		
☐**Viekira®**	☐ ombitasvir, paritaprevir, ritonavir (pink tablets): 12.5/75/50 mg dasabuvir (beige tablets) 250 mg [PAK]	☐ Take 2 ombitasvir, paritaprevir, ritonavir (pink) tablets orally once a day AM and 1 dasabuvir (beige) tablet orally twice daily AM and PM with a meal **Duration:** ☐ 12 weeks ☐ 24 weeks ☐ **Other:**_____ ☐ **Other:**_____		
☐**Vosevi®**	☐ 400/100/100 mg sofosbuvir/velpatasvir/voxilaprevir tablet	☐ Take 1 tablet orally once a day with food Select previous treatment experience if applicable ☐ Previous use of NS5A ☐ Previous use of sofosbuvir without NS5A ☐ **Other:**_____		
☐**Zepatier®**	50 mg elbasvir/100mg grazoprevir tablet NS5A resistant polymorphisms: ☐ Yes ☐ No	☐ Take 1 tablet orally once a day **Duration:** ☐ 12 weeks ☐ 24 weeks ☐ **Other:**_____ ☐ **Other:**_____		
☐**Other**				

DELIVERY INFORMATION

Need by: _____ Deliver to: ☐ Patient's home ☐ MD Office/Clinic ☐ Other:_____

PRESCRIBER'S SIGNATURE REQUIRED

MD | NP | PA Signature:_____ ☐ **DAW** **Date:** _____

*Signature on this form also provides consent to contact this patient's insurance provider for this prescription on the provider's behalf.

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CareMed SPECIALTY PHARMACY

Hepatitis Prescription Form

PATIENT INFORMATION You may also fax demographics/face sheet

Patient Name:_____ DOB: _____
SSN: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Cell Phone: _____
Known Allergies: _____
Height: _____ Weight: _____ lbs. ☐ M ☐ F
Emergency Contact: _____
Emergency Contact Phone: _____

INSURANCE INFO. Please fax copy of ALL insurance cards *front & back

Primary Insurance: _____
City, State: _____
ID Number: _____
Group Number: _____ Rx Bin: _____
Secondary Insurance: _____
City, State: _____
ID Number: _____
Group Number: _____ Rx Bin: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ License: _____ DEA: _____
Address: _____ City, State, Zip: _____
Office Contact: _____ Phone: _____ Fax: _____

DIAGNOSIS INFORMATION Please fax recent labs, clinical notes, etc. to help expedite the prior authorization process

☐ Hepatitis B ☐ Hepatitis C ☐ Other: _____
☐ ICD-10: _____
Prior Failed Therapies: _____ Reason For Discontinuation: _____

HEP B MEDICATIONS: You may tape Prescriptions here prior to faxing

MEDICATION	DOSE/STRENGTH	SIG	QTY	REFILLS
☐**Baraclude®**	☐ 0.5 mg tablets ☐ 1 mg tablets	☐ Take 1 tablet orally once a day ☐ **Other:** _____		
☐**Epivir-HBV®**	☐ 100 mg tablets ☐ 5 mg/mL Oral Solution	☐ Take 1 tablet orally once a day ☐ **Other:** _____		
☐**Hepsera®**	☐ 10 mg tablets	☐ Take 1 tablet orally once a day ☐ **Other:** _____		
☐**Vemlidy®**	☐ 25 mg tablets	☐ Take 1 tablet orally once a day ☐ **Other:** _____		
☐**Viread®**	☐ 150 mg tablets ☐ 200 mg tablets ☐ 250 mg tablets ☐ 300 mg tablets ☐ 40 mg/1 g Oral Powder	☐ Take 1 tablet orally once a day ☐ **Other:** _____		
☐**Other**				

DELIVERY INFORMATION

Need by: _____ **Deliver to:** ☐ Patient's home ☐ MD Office/ Clinic ☐ Other: _____

PRESCRIBER'S SIGNATURE REQUIRED

MD | NP | PA Signature: _____ ☐ **DAW** **Date:** _____

*Signature on this form also provides consent to contact this patient's insurance provider for this prescription on the provider's behalf.