benevere PHARMACY

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beneverepharmacy.com

TODAY'S DATE: ____________

☐ NEW PATIENT ☐ CURRENT PATIENT

HEPATITIS C REFERRAL FORM

PATIENT INFORMATION

Patient Name ____________
Address ____________
City ____________ State ____________ ZIP ____________
Home Phone ____________ Cell ____________
DOB ____________ SSN ____________
Drug Allergies ____________ ☐ Male ☐ Female

PRESCRIBER INFORMATION

Prescriber Name ____________ DEA ____________
NPI# ____________ Tax ID ____________
Practice Name ____________
Address ____________ Suite ____________
City ____________ State ____________ ZIP ____________
Office Phone ____________ Fax ____________

INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Insurance ____________
Insurance Phone ____________
Secondary Insurance (if applicable) ____________
Insurance Phone ____________

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARDS

CLINICAL INFORMATION

Diagnosis: ☐ B18.2 Chronic Hepatitis C without hepatic coma ☐ Other ____________ Genotype ____________ Diagnosis date: ____________

HCV viral load ____________IU/ml METAVIR: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4 ☐ Other Polymorphism: ____________

Previous Treatment: ☐ Naïve ☐ Relapse ☐ Treatment Failure Previous Regimen/Duration: ____________ CKD Stage: ____________

Dialysis: ☐ Yes ☐ No Child-Pugh: ☐ A ☐ B ☐ C Co-infection? ☐ HBV ☐ HIV If applicable, please send all clinical information pertinent to the patient's co-infection. Scr ________ Date ________

PLEASE ATTACH A LIST OF PATIENT'S CURRENT MEDICATIONS.

DRUG NAME	DOSE	DIRECTIONS FOR USE	WEEKS
☐ Daklinza®	60mg tablet	☐ Take once daily with or without food. ☐ Clinical Pharmacist consult on dosing for cytochrome P450 drug/drug interactions ☐ ____________	☐ 12 ☐ 24
☐ Epclusa®	400/100mg	Take once daily with or without food.	☐ 12 ☐ 24
☐ Harvoni®	90/400mg	Take once daily with or without food.	☐ 8 ☐ 12 ☐ 24
☐ Mavyret®	300/120mg	Take 3 tablets once daily with food.	☐ 8 ☐ 12 ☐ 16
☐ Moderiba® ☐ RibaPak®	***Weight (kg)*** ***Strength (Dose)*** ≤ 75 1000 mg/day > 75 1200 mg/day Dose reduction required with renal insufficiency.	☐ 600mg P O Daily; 200mg QAM, 400mg QPM ☐ 800mg P O Daily; 400mg QAM, 400mg QPM ☐ 1000mg P O Daily; 600mg QAM, 400mg QPM ☐ 1200mg P O Daily; 600mg QAM, 600mg QPM Divided and administered twice-daily with food.	☐ 8 ☐ 12 ☐ 16 ☐ 24
☐ Ribavirin	☐ 200mg tablets ☐ 200mg capsules	Sig: ____________	☐ 8 ☐ 12 ☐ 16 ☐ 24
☐ Sovaldi®	400mg tablet	Take once daily with or without food.	☐ 12 ☐ 24 ☐ 48
☐ Technivie® Pak		Take 2 tablets in the morning with a meal per pack directions	☐ 12
☐ Viekira® Pak		Take 3 tablets in the morning and 1 tablet at night with a meal per pack directions.	☐ 12 ☐ 24
☐ Viekira® XR		Take 3 tablets by mouth once daily with food	☐ 12 ☐ 24
☐ Vosevi®	400/100/100mg	Take once daily with food.	☐ 12
☐ Zepatier®	50/100mg	Take once daily with or without food. *For HCV 1a patients, please send baseline NS5A resistance-associated polymorphism test results.*	☐ 12 ☐ 16

Deliver to: ☐ Patient's home ☐ MD's Office ☐ 1st dose to MD's Office, remaining refills to patient's home

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

Prescriber's Signature (signature required. NO STAMPS) ____________ Date ____________

By signing this form and utilizing our services, you are authorizing Benevere and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you