Hepatitis C
enrollment form

Phone: 855-425-4085   **Fax:** 855-425-4096   **ardonhealth.com**

ardon

Date needed	Medication start date	Ship to: ☐ Patient ☐ Physician ☐ Other:

Patient information

Patient name		Date of birth		Phone	Alternate phone
Address			City	State	ZIP
Gender: ☐ Male ☐ Female	Email		Primary language	Height	Weight

Prescriber information

Prescriber name	State License #		NPI #	DEA #
Group or hospital	Address		City	State	ZIP
Phone	Fax	Contact person name and phone		

Insurance information: If available, please fax a copy of the prescription and insurance card(s) with this form (front and back).

Clinical

Date of diagnosis	Diagnosis ICD-10 code: ☐ Chronic Viral Hepatitis C B18.2 Viral load: _____ Date: _____
Previous medications for HCV:	Current medications:
Allergies:	HCV therapy treatment duration: _____ weeks
Previously treated for HCV? ☐ Yes ☐ No	Fibrosis: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4
Genotype: ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6	Child-Pugh score:

Prescription information

Medication	Dose/strength	Directions	Quantity	Refill
☐ Epclusa ☐ Sofosbuvir/ Velpatasvir	☐ 400/100 mg Tablet	☐ Take 1 tablet by mouth once daily	☐ 28 Tablets	
☐ Epclusa (Pediatric)	☐ 200/50 mg Tablet ☐ 200/50 mg Packet	☐ Take _____ tablet(s)/packet(s) by mouth once daily	_____ Tablets/ Packets	
	☐ 150/37.5 mg Packet	☐ Take 1 packet by mouth once daily	☐ 28 Packets	
☐ Harvoni ☐ Ledipasvir/ Sofosbuvir	☐ 90/400 mg Tablet	☐ Take 1 tablet by mouth once daily	☐ 28 Tablets	
☐ Harvoni (Pediatric)	☐ 45/200 mg Tablet ☐ 45/200 mg Packet	☐ Take _____ tablet(s)/packet(s) by mouth once daily	_____ Tablets/ Packets	
	☐ 33.75/150 mg Packet	☐ Take 1 packet by mouth once daily	☐ 28 Packets	

Physician signature required

Product substitution permitted	Dispense as written
X _____ Date _____	X _____ Date _____

Ancillary supplies and kits will be provided as needed for administration.

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☐ Mavyret	☐ 100/40 mg Tablet	☐ Take 3 tablets by mouth once daily with food	☐ 84 Tablets	
☐ Mavyret (Pediatric)	☐ 50/20 mg Packet	☐ Take _____ packets by mouth once daily with food	_____ Packets	
☐ Ribavirin	☐ 200 mg Tablet ☐ 200 mg Capsule	☐ Take _____ tablet(s)/capsule(s) by mouth every morning and _____ tablet(s)/capsule(s) every evening	_____ Tablets/ Capsules	
☐ Sovaldi	☐ 400 mg Tablet	☐ Take 1 tablet by mouth once daily	☐ 28 Tablets	
☐ Sovaldi (Pediatric)	☐ 200 mg Tablet ☐ 200 mg Packet	☐ Take _____ tablet(s)/packet(s) by mouth once daily	☐ 28 Tablets/ Packets	
	☐ 150 mg Packet	☐ Take 1 packet by mouth once daily	☐ 28 Packets	
☐ Vosevi	☐ 400/100/100 mg Tablet	☐ Take 1 tablet by mouth once daily with food	☐ 28 Tablets	
☐ Zepatier	☐ 50/100 mg Tablet	☐ Take 1 tablet by mouth once daily *If GT 1a, has NS5A resistance testing been completed?* ☐ Yes ☐ No *If yes, does the patient have baseline NS5A polymorphisms?* ☐ Yes ☐ No	☐ 28 Tablets	
☐ Other				

Physician signature required

Product substitution permitted

X _____ Date _____

Dispense as written

X _____ Date _____

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