ardon

Hepatitis C Enrollment Form
Phone: 855-425-4085
Fax: 855-425-4096
ardonhealth.com

PATIENT INFORMATION

Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Primary Phone: _____ DOB: _____
Alternate Phone: _____ Gender: ☐ Male ☐ Female
Email: _____
Last Four of SS #: _____ Primary Language: _____
Height: _____ Weight: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ NPI #: _____
DEA #: _____
Group or Hospital: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

INSURANCE INFORMATION: PLEASE FAX A COPY OF THE PRESCRIPTION & INSURANCE CARDS WITH THIS FORM, IF AVAILABLE (FRONT & BACK)

CLINICAL

Need By Date:	**Ship to**: ☐ Patient ☐ Physician ☐ Other:
Date of Diagnosis:	**Diagnosis ICD-10 Code: Chronic Viral Hepatitis C B18.2** ☐ **Viral Load:** **Date:**
Previous Failed 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**	☐ 400/100mg Tab	☐ Take 1 Tab PO Daily	☐ 28	☐
☐ **Vosevi**	☐ 400/100/100mg Tab	☐ Take 1 Tab PO Daily with food	☐ 28	☐
☐ **Mavyret**	☐ 100/40mg Tab	☐ Take 3 Tabs PO Daily with food	☐ 84	☐
☐ **Harvoni**	☐ 400/90mg Tab	☐ Take 1 Tab PO Daily	☐ 28	☐
☐ **Sovaldi**	☐ 400mg Tab	☐ Take 1 Tab PO Daily	☐ 28	☐
☐ **Ribavirin**	☐ 200mg Tab ☐ 200mg Cap	☐ Take ____mg PO Every Morning and ____mg PO Every Evening	____	☐
☐ **Technivie**	☐ 12.5/75/50mg	☐ Take 2 Tabs PO Daily	☐ 56	☐
☐ **Daklinza**	☐ 30mg Tab ☐ 60mg Tab ☐ 90mg Tab	☐ Take 1 Tab PO Daily	☐ 28	☐
☐ **Zepatier**	☐ 50-100mg Tab	☐ Take 1 Tab PO Daily Has NS5A resistance testing been completed? ☐Yes ☐ No	☐ 28	☐
☐ **Olysio**	☐ 150mg Cap	☐ Take 1 Cap PO Daily	☐ 28	☐
☐ **Other**			☐	☐

X _____ (Date)
PRODUCT SUBSTITUTION PERMITTED

X _____ (Date)
DISPENSE AS WRITTEN

PHYSICIAN SIGNATURE REQUIRED

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

Date Needed: _____ Medication Start Date: _____

This prescription is valid only if transmitted by facsimile machine by a licensed provider.