ardon

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

PATIENT INFORMATION		PRESCRIBER INFORMATION	
Patient Name:		Prescriber's Name:	
Address:		State License #:	NPI #:
City:	State: Zip:	DEA #:	
Primary Phone:	DOB:	Group or Hospital:	
Alternate Phone:	Gender: ☐ Male ☐ Female	Address:	
Email:		City:	State: Zip:
Primary Language:		Phone:	Fax:
Height:	Weight:	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 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 INFORMATIONs

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILL
☐ **Epclusa** ☐ **Sofosbuvir/Velpatasvir**	☐ 400/100mg Tab	☐ Take 1 tab PO daily	☐ 28	____
☐ **Epclusa (Pediatric Patients < 30 kg)**	☐ 200/50mg Tab	☐ Take 1 tab PO daily	☐ 28	____
☐ **Harvoni** ☐ **Ledipasvir/Sofosbuvir**	☐ 90/400 Tab	☐ Take 1 tab PO daily	☐ 28	____
☐ **Harvoni (Pediatric Patients < 35 kg)**	☐ 45/200mg Tab ☐ 45/200mg Packet ☐ 33.75/150mg Packet	☐ Take 1 tab/packet PO once daily	☐ 28	____
☐ **Mavyret**	☐ 100/40mg Tab	☐ Take 3 tabs PO daily with food	☐ 84	____
☐ **Ribavirin**	☐ 200mg Tab ☐ 200mg Cap	☐ Take ____mg PO every morning and ____mg PO every evening	____	____
☐ **Sovaldi**	☐ 400mg Tab	☐ Take 1 tab PO daily	☐ 28	____
☐ **Sovaldi (Pediatric Patients < 35 kg)**	☐ 200mg tab ☐ 200mg packet ☐ 150mg packet	☐ Take 1 tab/packet PO once daily	☐ 28	____
☐ **Vosevi**	☐ 400/100/100mg Tab	☐ Take 1 tab PO daily with food	☐ 28	____
☐ **Zepatier**	☐ 50-100mg Tab	☐ Take 1 tab PO daily If GT 1a: Has NS5A resistance testing been completed? ☐Yes ☐ No If Yes: Does the patient have baseline NS5A polymorphisms? ☐Yes ☐ No	☐ 28	____
☐ **Other**			☐_____	____

X _____ (Date)
PRODUCT SUBSTITUTION PERMITTED
Ancillary supplies and kits will be provided as needed for administration.

X _____ (Date)
DISPENSE AS WRITTEN

PHYSICIAN SIGNATURE REQUIRED

Date Needed: _____ Medication Start Date: _____

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