

**Hepatitis C Enrollment Form**

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ardonhealth.com

PATIENT INFORMATION	Patient Name: _____	PRESCRIBER INFORMATION	Prescriber's Name: _____
	Address: _____		State License #: _____ NPI #: _____
	City: _____ State: _____ Zip: _____		DEA #: _____
	Primary Phone: _____ DOB: _____		Group or Hospital: _____
	Alternate Phone: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> Patient <input type="checkbox"/> Physician <input type="checkbox"/> Other: _____
	Date of Diagnosis: _____	Diagnosis ICD-10 Code: Chronic Viral Hepatitis C B18.2 <input type="checkbox"/> Viral Load: _____ Date: _____
	Previous Medications for HCV: _____	
	Current Medications: _____	
	Allergies: _____ HCV Therapy Treatment Duration: _____ weeks	
	Previously treated for HCV? <input type="checkbox"/> Yes <input type="checkbox"/> No Fibrosis: <input type="checkbox"/> F0 <input type="checkbox"/> F1 <input type="checkbox"/> F2 <input type="checkbox"/> F3 <input type="checkbox"/> F4	
	Genotype <input type="checkbox"/> 1a <input type="checkbox"/> 1b <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 Child-Pugh Score: _____	

PRESCRIPTION INFORMATION	MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILL												
	<input type="checkbox"/> Epclusa <input type="checkbox"/> Sofosbuvir/Velpatasvir	<input type="checkbox"/> 400/100mg Tab	<input type="checkbox"/> Take 1 tab PO daily	<input type="checkbox"/> 28	____												
	<input type="checkbox"/> Epclusa (Pediatric)	<input type="checkbox"/> 200/50mg Tab	<input type="checkbox"/> Take 1 tab PO daily	<input type="checkbox"/> 28	____												
		<input type="checkbox"/> 150/37.5mg Packet	<input type="checkbox"/> Take ____ packets PO once daily	____	____												
	<input type="checkbox"/> Harvoni <input type="checkbox"/> Ledipasvir/Sofosbuvir	<input type="checkbox"/> 90/400 Tab	<input type="checkbox"/> Take 1 tab PO daily	<input type="checkbox"/> 28	____												
	<input type="checkbox"/> Harvoni (Pediatric Patients < 35 kg)	<input type="checkbox"/> 45/200mg Tab	<input type="checkbox"/> Take 1 tab/packet PO once daily	<input type="checkbox"/> 28	____												
		<input type="checkbox"/> 45/200mg Packet															
		<input type="checkbox"/> 33.75/150mg Packet															
	<input type="checkbox"/> Mavyret	<input type="checkbox"/> 100/40mg Tab	<input type="checkbox"/> Take 3 tabs PO once daily with food	<input type="checkbox"/> 84	____												
		<input type="checkbox"/> 50/20mg Packet	<input type="checkbox"/> Take ____ packets PO once daily with food	____	____												
<input type="checkbox"/> Ribavirin	<input type="checkbox"/> 200mg Tab <input type="checkbox"/> 200mg Cap	<input type="checkbox"/> Take ____mg PO every morning and ____mg PO every evening	____	____													
<input type="checkbox"/> Sovaldi	<input type="checkbox"/> 400mg Tab	<input type="checkbox"/> Take 1 tab PO daily	<input type="checkbox"/> 28	____													
<input type="checkbox"/> Sovaldi (Pediatric Patients < 35 kg)	<input type="checkbox"/> 200mg tab <input type="checkbox"/> 200mg packet <input type="checkbox"/> 150mg packet	<input type="checkbox"/> Take 1 tab/packet PO once daily	<input type="checkbox"/> 28	____													
<input type="checkbox"/> Vosevi	<input type="checkbox"/> 400/100/100mg Tab	<input type="checkbox"/> Take 1 tab PO daily with food	<input type="checkbox"/> 28	____													
<input type="checkbox"/> Zepatier	<input type="checkbox"/> 50-100mg Tab	<input type="checkbox"/> Take 1 tab PO daily If GT 1a: Has NS5A resistance testing been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: Does the patient have baseline NS5A polymorphisms? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 28	____													
<input type="checkbox"/> Other			<input type="checkbox"/> _____	____													
PHYSICIAN SIGNATURE REQUIRED																	
<table border="0"><tr><td>X</td><td>PRODUCT SUBSTITUTION PERMITTED</td><td>(Date)</td><td>X</td><td>DISPENSE AS WRITTEN</td><td>(Date)</td></tr><tr><td colspan="6">Ancillary supplies and kits will be provided as needed for administration.</td></tr></table>						X	PRODUCT SUBSTITUTION PERMITTED	(Date)	X	DISPENSE AS WRITTEN	(Date)	Ancillary supplies and kits will be provided as needed for administration.					
X	PRODUCT SUBSTITUTION PERMITTED	(Date)	X	DISPENSE AS WRITTEN	(Date)												
Ancillary supplies and kits will be provided as needed for administration.																	

Date Needed: _____ Medication Start Date: _____

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