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: _____
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 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)**	☐ 200/50mg Tab	☐ Take 1 tab PO daily	☐ 28	____
	☐ 150/37.5mg Packet	☐ Take ____ packets PO once daily	____	____
☐ **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 once daily with food	☐ 84	____
	☐ 50/20mg Packet	☐ Take ____ packets PO once daily with food	____	____
☐ **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.

PHYSICIAN SIGNATURE REQUIRED

X _____ (Date)
DISPENSE AS WRITTEN

Date Needed: _____ Medication Start Date: _____

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