SMP PHARMACY SOLUTIONS

Fax#: 855-447-6637
Ph#: 855-650-5009

Hepatitis Prescription Faxable

Today's Date: _____ **Needed by:** _____ **Name:** _____ **Phone:** _____

Patient Demographic: (Provide the following or attached demographic sheet)
Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Alt. Phone: _____
SS#: _____ Date Birth: _____
Gender: _____ Height: _____ Weight_____ BSA ____ m2

Prescriber: (Provide as much information as possible)
Prescriber's Name: _____ Group/Hospital: _____
Specialty: _____ NPI #: _____ DEA: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Alt. Contact Name: _____
Phone: _____ Position: _____

Insurance Information (Please copy and attach the front and back of the Insurance Card):
Primary Insurance Name: _____ ID# _____ BIN#: _____ Group#: _____ PCN#: _____ Phone: _____
☐ No Insurance ☐ Patient will pay out of pocket ☐ Enroll in Manufacturer's Patient Assistance Program

Medication Delivery to (Choose Only One):
☐ Patient Address ☐ First Fill Physician's Office, Refill to Patient Address ☐ Patient will pick up at Pharmacy

Diagnosis (ICD- 10 code):
☐ B17.10 Acute Hepatitis C without hepatic come ☐ B17.11 Acute Hepatitis C with hepatic come ☐ B18.2 Chronic Hepatitis C
☐ B19.20 Unspecified Viral Hepatitis C without hepatic coma ☐ B20 HIV ☐ T86.40 Liver Transplant ☐ Other: _____

Patient Evaluation:
Height: _____in/cm Weight: _____ kg/lbs. Allergies: _____
HCV Genotype ☐ 1a ☐ 1b ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 AND ☐ No Cirrhosis ☐ Compensated Cirrhosis ☐ Uncompensated Cirrhosis
Is patient: ☐ Naïve ☐ Partial Responder ☐ Non-Responder ☐ Relapser; Last Date of Therapy: _____ Product Names: _____
Is patient currently on Hepatitis C Virus (HCV) therapy? ☐ Yes ☐ No; If Yes, Therapy Start Date: _____ Product Names: _____

MEDICATION	STRENGTH	DIRECTION	Qty. SUPPLY	REFILLS
☐ **Epclusa** (sofosbuvir/velpatasvir)	☐ One tablet contains 400 mg sofosbuvir and 100 mg velpatasvir.	One tablet orally once a day with or without food (Patients with decompensated cirrhosis, add Ribavirin)	28 day	
☐ **Harvoni** (ledipasvir/sofosbuvir)	☐ Fixed-dose combination tablet of 90mg of ledipasvir/400mg of sofosbuvir.	Take orally once daily with or without food (Do not take within 4 hours of antacids)	28 day	
☐ **Mavyret**	☐100/40mg	Take 3 Tabs daily	28 day	
☐ **Ribavirin**	☐200 mg tabs ☐ 200mg caps	Take _____tabs/caps PO QAM and _____ tabs/caps PO QPM to equal a total of _____mg/day		
☐ **Risbasphere RIBA-PAK**	☐ 600/600 mg tabs ☐ 600/400mg ☐ 400/400 mg tabs ☐ 200/400mg	Take _____ mg PO QAM and _____ QPM to equal a total of _____mg/day		
☐ **Viekira Pak** (ombitasvir/paritaprevir/ ritonavir tablets and dasabuvir tablets)	Viekira Pak: ombitasvir/paritaprevir/ritonavir 12.5/75/50 mg and dasabuvir 250 mg copackaged	Take two pink tablets (ombitasvir, partiaprevir, ritonavir) once daily (morning) and one beige tablet (dasabuvir) twice daily (morning and evening) with meals.	28 day	
☐ **Viekira XR** (dasabuvir/ombitasvir/ paritaprevir/ritonavir)	Extended release tablets 200mg dasabuvir, 8.33 mg ombitasvir, 50mg paritaprevir and 33.33 mg ritonavir	Take 3 tablets once daily with a meal ☐ Add Ribavirin	28 day	
☐ **Vosevi**	☐ 400 / 100 /100	Take one tablet daily	28 day	
☐ **Zepatir** (elbasvir/grazoprevir)	☐One tablet contains 50 mg elbasvir and 100 mg grazoprevir	One tablet orally once a day with or without food ☐ Add Ribavirin	28 day	
☐ **Other**				

By signing this form and utilizing our services, you are authorizing SMP and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

_____ Prescriber Signature

_____/_____/_____ Date