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