SMP PHARMACY SOLUTIONS

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

Hepatitis Prescription Faxable

Patient Demographic: *Provide the following or attach demographic sheet*

Patient Name: _____

Address: _____

City, State, Zip: _____

Phone:_____ Alt. Phone:_____

SS#:_____ Date of 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: _____

Contact Name:_____ Phone: _____

Insurance Information - Please provide a copy of the front and back of the insurance card.

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): Hep C: ☐_____ ☐_____ ☐_____ Hep B: ☐_____ ☐_____ ☐_____

Patient Allergies / Allergic Reactions:

1._____2. _____

Prior (Failed) Medications (Reason for D/C):

1._____2. _____

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		
☐ **Vemlidy**	☐ 25mg tabs	Take 1 tablet daily		
☐ **Viread**	☐ 150 mg tabs ☐ 300 mg tabs	Take 1 tablet daily		
☐ **Vosevi**	☐ 400 / 100 /100	Take 1 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's Signature

_____/_____/_____ Date