

Patient Information				Prescriber Information														
Patient Name:		DOB:		Prescriber's Name:														
Address:				NPI#:														
City:	State:	Zip:		DEA#:		License#:												
Phone:		Alternate Phone:		SSN:		Address:												
Height:	Weight:	Allergies:		Phone:		Fax:												
Emergency Contact:		Phone:		Contact Person:														
Is the patient pregnant, planning a pregnancy or nursing:				Yes	No	Does the patient need interpreter services:		Yes	No									
Genotype	1a	1b	2	3	4	5	6	Tx naïve?	Y	N	Cirrhosis	Y	N	Fibrosis	F1	F2	F3	F4

Hep C Medication	Directions for Use	Qty	Refills
EPCLUSA® (Sobosbuvir / Velpatasvir)	Take 1 tablet by mouth daily	#28	
HARVONI® (Sobosbuvir / Ledipasvir)	Take 1 tablet by mouth daily	#28	
MAVYRET® (Glecaprevir / Pibrentasvir)	Take 3 tablets by mouth daily <b>with food</b>	#84	
VOSEVI® (Sofosbuvir / Velpatasvir / Voxilaprevir)	Take 1 tablet by mouth daily <b>with food</b>	#28	
ZEPATIER® (Elbasvir / Grazoprevir)	Take 1 tablet by mouth daily	#28	
RIBAVIRIN MODERIBA RIBAPACK	Take 200mg PO QAM & 400mg PO QPM Take 400mg PO QAM & 400mg PO QPM < 75kg Take 600mg PO QAM & 400mg PO QPM > 75kg Take 600mg PO QAM & 600 PO QPM	#84 #112 #140 #168	

Hep B Medication	Strength	Directions for Use	Qty	Refills
BARACLUDE®	0.5mg	0.5mg tab PO daily (Naive pt or adolescents ≥ 16 yo)	#30	
	1mg	1mg tab PO daily (Lamivudine -Refractory pt)		
	0.05mg/ml:	0.05mg/ml		
	Dose adjustment by Creatinine Clearance (if less than 50ml/min):			
EPIVIR HBV®	100mg	100 mg by mouth daily	#30	
HEPSERA®	10mg	100mg PO daily Dose adjustment by Creatinine Clearance (if less than 50 ml/min):	#30	
HBIG® Hepatitis B Immune Globulin - single use vial		5ml IM in 2 divided doses, every 2ml IM in 2 divided doses, every 10,000 International Units(32ml) in 250ml NS, IV over ____ hour(s), every ____ for ____ infusions Alternative Dosage: _____		
PEGASYS® Prefilled Syringe Vial ProClick®	180mcg	90mcg SQ once weekly	#28	
	135mcg	180mcg SQ once weekly		
		135mcg SQ once weekly		
TYZEKA®	600mg	600mg by mouth daily Dose adjustment by Creatinine Clearance (if less than 50ml/min)	#30	
VELMIDY®	25mg	25mg by mouth daily with food	#30	
VIREAD®	300mg	300mg PO daily Dose adjustment by Creatinine Clearance (if less than 50ml/min):	#30	

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature \_\_\_\_\_

Date \_\_\_\_\_