HCV

Thrifty White PHARMACY Specialty Services
toll-free phone: **888-558-9941** | toll-free fax: **855-826-2596**

Patient Information

Patient Name: ______________________________ DOB: __________
Sex: ❑ Female ❑ Male SS #: ______________________________
1° Language: _____________ Wt:______❑kg ❑lbs Ht:______❑cm ❑in
Ethnicity: ❑ Asian ❑ Black ❑ Hispanic ❑ White ❑ Other__________
Address: ____
Apt/Suite #________ City:______________ State:_______ Zip:_______
Primary Phone:________________ Alternate Phone:________________
Caregiver name: ________________________ Relation: ____________
Local Pharmacy: ________________________ Phone: ____________
Insurance Plan: __________________ Plan ID # __________________
Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber Name:____
NPI #: ____
Address: ____
Apt/Suite #________ City:____________ State:_______Zip:________
Contact: ____
Phone: ______________________ Alternate: ____________________
Fax: ____
Email address____
If shipping to prescriber: ❑ 1st Fill ❑ Always ❑ Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis ICD-10: ❑ B18.2 HCV (chronic) ❑ Other ________________
Genotype: ❑ 1a ❑ 1b ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6
Baseline Viral Load: __________________ Date: __________________
Degree of fibrosis: ❑ F0 ❑ F1 ❑ F2 ❑ F3 ❑ F4
Other Fibrosis Score: ____
Cirrhosis: ❑ none ❑ compensated ❑ decompensated
Transplant status: ❑ N/A ❑ Pre-transplant ❑ Post-transplant
IL28B: ❑ CC ❑ CT ❑ TT

Patient type: ❑ naïve ❑ relapser ❑ partial responder ❑ null responder
Any prior treatment: ❑ No ❑ Yes (provide information below)
Med:_________________ From ________ To _________ Weeks _____
Med:_________________ From ________ To _________ Weeks _____
Med:_________________ From ________ To _________ Weeks _____
Co-infection(s): ❑ none ❑ HIV ❑ HBV
Other Comorbidities:____
Allergies: ❑ NKDA ❑ Other__________________________________

Prescription Information

❑ **Harvoni®** 90 mg/400 mg tablet QD
Quantity: 28 Refill: ___________________
Anticipated treatment duration: ❑ 8 weeks ❑ 12 weeks ❑ 24 weeks

❑ **Sovaldi®** 400 mg tablet QD
Quantity: 28 Refill: ___________________
Anticipated treatment duration: ❑ 12 weeks ❑ 24 weeks

❑ **Viekira Pak™** Take 3 tablets in the AM and 1 tablet in the PM with food.
Quantity: 112 Refill:___________________
Anticipated treatment duration: ❑ 12 weeks ❑ 24 weeks

❑ **Daklinza®**
❑ 60 mg tablet QD Quantity: 28 Refill: ____________________
❑ 30 mg tablet QD Quantity: 28 Refill: ____________________
Anticipated treatment duration: ❑ 12 weeks ❑ 24 weeks

❑ **Technivie™** Take 2 tablets in the AM with food.
Quantity: 56 Refill:___________________
Anticipated treatment duration: ❑ 12 weeks

❑ **Olysio®** 150 mg capsule QD
Quantity: 28 Refill: ___________________
Anticipated treatment duration: ❑ 12 weeks ❑ 24 weeks

❑ **Pegasys® PFS** 180 mcg SQ QWK (4 PFS) Refill:______________
❑ **Pegasys® Proclick™** 180 mcg/0.5 mL SQ QWK (4 Autoinjector)

Other dose and Sig:____
Refill: ________________

❑ **Ribasphere® Ribapak Dose Pak OR** ❑ **Moderiba™ Dose Pack** **Refill: ___________________**
❑ 1000 mg/day 600 mg tablet QAM, 400 mg tablet QPM (56 tabs)
❑ 600 mg/day 200 mg tablet QAM, 400 mg tablet QPM (56 tabs)
❑ 1200 mg/day 600 mg tablet QAM, 600 mg tablet QPM (56 tabs)
❑ 800 mg/day 400 mg tablet QAM, 400 mg tablet QPM (56 tabs)

❑ **Ribasphere® OR** ❑ **Ribavirin** 200 mg ❑ Tablet ❑ Capsule **Refill: ___________________**
❑ 1000 mg/day Take 3 tabs/caps QAM, 2 tabs/caps QPM (140 tabs)
❑ 600 mg/day Take 1 tabs/caps QAM, 2 tabs/caps QPM (84 tabs)
❑ 1200 mg/day Take 3 tabs/caps QAM, 3 tabs/caps QPM (168 tabs)
❑ 800 mg/day Take 2 tabs/caps QAM, 2 tabs/caps QPM (112 tabs)

Prescriber's Signature:____ Date: ________________
I authorize Thrifty White Specialty Pharmacy Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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