Phone: 1-888-792-1552
Fax: 1-888-216-2510

To ePrescribe send prescription to:
Giant Eagle Pharmacy
20160 Center Ridge Road, Suite 201
Rocky River, OH 44116

HEPATITIS C ENROLLMENT FORM

Today's Date: ____________________

Ship to: ☐ Patient ☐ Physician ☐ Store for Patient Pick-up **Date Shipment Needed:**_____________ **Rx:** ☐ New ☐ Refill **RN Instruction Needed:** ☐ Yes ☐ No
All supplies, including syringes and needles, will be dispensed if needed.

Patient Information

Date: ____________________ DOB: __________________________ ☐ Male ☐ Female SSN # ____________________________
Patient's First Name: ______________________________________ Patient's Last Name: ______________________________
Address: ______________________________________ City: ___________________________ State: ________ ZIP: ______________
Best Phone #: ____ Alternate Phone #: ________________________________
Height: __________ Weight: __________ Caregiver: ____________________________ Allergies: ____________________________
Store Preference (address): ____

Insurance Information: Please fax copy of insurance card (front + back)

Primary Insurance: ____ Phone: ____
Policy #: ____ Group #: ____

Medical Necessity

Primary Diagnosis: ______________________ Allergies: ____________________ RNA / Date: _________________________________
ICD-10: ☐ B18.2 Chronic viral Hepatitis C ☐ Other ICD-10:___________________ Viral Load: ______________________________
Genotype: ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ Other: ____
Previously treated for HCV? ☐ Yes ☐ No If yes, was patient a: ☐ Non-Responder [OR] ☐ Responder/Relapser
Previous Treatment: ____ Treatment Duration: From _______________ To _______________
Other medication patient is currently taking including OTC medications (or fax medication profile): _____________________________
____

Prescription

☐ **HARVONI®** (ledipasvir and sofosbuvir)
Qty: 28 Day Supply
Ledipasvir 90 mg/sofosbuvir 400 mg, 1 tablet PO QD
Refill x: _______________

☐ **MAVYRET®** (glecaprevir 100mg and pibrentasvir 40mg)
Qty: 28 Day Supply
Take 3 Tablets (total daily dose: glecaprevir 300mg and pibrentasvir 120mg) by mouth once daily with food
Refill x: _____________________

☐ **EPCLUSA®** (sofosbuvir and velpatasvir)
Qty: 28 Day supply
Sofosbuvir 400mg/Velpatasvir 100mg, 1 tablet PO QD
Refill x: ____________

☐ **VIEKIRA XR®** (dasabuvir, ombitasvir, paritaprevir; ritonavir)
Qty: 28 Day Supply
Dasabuvir 200mg, Ombitasvir 8.33mg, Paritaprevir 50mg, Ritonavir 33.33 mg: 3 tablets PO QD w/ food
Refill x: _____________________

☐ **SOVALDI®** (sofosbuvir)
Qty: 28 Day Supply 400 mg tablet QD
Refill x: ____________________

☐ **VIEKIRA PAK®** (ombitasvir, paritaprevir, ritonavir; dasabuvir)
Qty: 28 Day Supply
Ombitasvir 12.5 mg, Paritaprevir 75 mg, Ritonavir 50 mg: 2 Tablets PO QAM w/food; Dasabuvir 250 mg: 1 tablet PO BID w/food
Refill x: ____________________

☐ **DAKLINZA®** (declatasvir)
Qty: 28 Day Supply
☐ 60mg 1 Tablet PO QD ☐ 30mg 1 Tablet PO QD ☐ 90mg PO QD
Refill x: ____________________

☐ **ZEPATIER®** (elbasvir and grazoprevir)
Qty: 28 Day Supply
Elbasvir 50mg/grazoprevir 100mg, 1 tablet PO QD
Refill x: ____________________

RIBAPAK™ (ribavirin)
☐ 400/400: 400mg AM & 400mg PM ☐ 600/400: 600mg AM & 400mg PM
☐ 600/600: 600mg AM & 600mg PM
Qty: 28 day supply Refill x: ____________

☐ **VOSEVI®** (sofosbuvir, velpatasvir, voxilaprevir)
Qty: 28 Day Supply
Sofosbuvir 400mg, Velpatasvir 100mg, Voxilaprevir 100mg: 1 tablet PO QD with food
Refill x: ____________________

RIBAVIRIN
☐ 800 mg/day ☐ 1000 mg/day ☐ 1200 mg/day
Qty: 28 day supply Refill x: ________________________

☐ **TECHNIVIE®** (ombitasvir, paritaprevir, and ritonavir)
Qty: 28 Day Supply
Ombitasvir 12.5mg, Paritaprevir 75mg, Ritonavir 50mg: 2 Tablets PO QAM w/food
Refill x: ____________________

Prescriber Information

Date prescription needed: ____
Physician Name (please print): __________________________________ Contact Name: ____________________________
Phone #: __________________________ Fax #:_______________________ NPI #: ____________________ Tax ID #: __________
Office Address: _____________________________________ City: _______________________ State: ______ ZIP: ____________

In order for a brand name to be dispensed, the prescriber must hand write "brand medically necessary" or "brand necessary" in the space below. ____

I authorize this prescription and for Giant Eagle Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
Physician Signature: ____ **Date:** ____________________