BFP | BROADWAY FAMILY PHARMACY

Hepatitis C Enrollment

Please Fax Completed Form To: 212-724-1946
510 Amsterdam Ave, STR1 (South Store) • New York, NY 10024 • tel 212-724-1950

PATIENT INFORMATION

Patient Name	DOB	SS#	
Address	City	State	Zip
Phone #	Alt Phone #	Email	
Allergies		Height	Weight
Sex: ☐ Male ☐ Female ☐ other:	Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ other:		

Please fax a copy of both sides of Patient's Insurance, Medicaid, or Medicare Part D Card

CLINICAL INFORMATION

Diagnosis / ICD10: ☐ B18.2 Chronic Hepatitis C ☐ B17.10 Acute Hepatitis C ☐ Z94.4 Liver Transplant ☐ B20 HIV ☐ Other

Genotype: ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 Responder Status: ☐ Naïve ☐ Relapsed ☐ Partial Responder ☐ Non-Responder

Previous Therapy When?

Viral Load AST ALT

Fibrosis Score Fibrosis Stage ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4 ☐ Cirrhosis ☐ Decompensated ☐ Liver Transplant Candidate

In order to expedite the prior authorization process, please fax copies of the patient's most recent progress notes and lab work. Please include: CBC, Chemistry, HCV Viral Load, HCV Genotype, Fibrosis Score. For Medicaid patients, include Drug and Alcohol Screenings (within 30 days.)

PRESCRIPTION INFORMATION

SHIP TO: ☐ Patient ☐ Physician's Office

Medication	Strength	Directions	Duration	Quantity	Refills
☐ Daklinza™ (daclatasvir)	☐ 30mg tablets ☐ 60mg tablets	Take _____ mg PO QD with or without food *administer with sofosbuvir	_____ weeks	4 Week Supply	_____
☐ Epclusa® (sofosbuvir/velpatasvir)	400mg / 100mg	Take one tablet PO QD with or without food	_____ weeks	4 Week Supply	_____
☐ Harvoni® (ledipisvir/sofosbuvir)	90mg / 400mg	Take one tablet PO QD with or without food	_____ weeks	4 Week Supply	_____
☐ Mavyret™ (glecaprevir/pibrentasvir)	100mg / 40mg	Take three tablets by mouth once daily with food	_____ weeks	4 Week Supply	_____
☐ Olysio™ (simeprevir)	150mg capsule	Take one 150mg tablet PO QD with food	_____ weeks	4 Week Supply	_____
☐ Sovaldi™ (sofosbuvir)	400mg tablets	Take one tablet PO QD with or without food	_____ weeks	4 Week Supply	_____
☐ Technivie™	12.5mg / 75mg / 50mg	Take two tablets PO QD with food *administer with ribavirin	_____ weeks	4 Week Supply	_____
☐ Viekira Pak™	Viekira Pak™	Take as Directed	_____ weeks	4 Week Supply	_____
☐ Viekira XR™	Viekira XR™	Take as Directed	_____ weeks	4 Week Supply	_____
☐ Vosevi™ (sofosbuvir/velpatasvir/voxilaprevir)	400mg / 100mg / 100mg	Take one tablet PO QD with food	_____ weeks	4 Week Supply	_____
☐ Zepatier™ (elbasvir/grazoprevir)	50mg / 100mg	Take one tablet PO QD with or without food	_____ weeks	4 Week Supply	_____
☐ Ribavirin	☐ 200mg tablets ☐ 200mg capsules ☐ 200mg Moderiba ☐ Moderiba Dose Pack ☐ Ribapak	☐ 1200mg: 600mg PO QAM, 600mg PO QPM ☐ 1000mg: 600mg PO QAM, 400mg PO QPM ☐ 800mg: 400mg PO QAM, 400mg PO QPM ☐ 600mg: 400mg PO QAM, 200mg PO QPM ☐ Other: ____ mg: take ____ PO QAM and ____ PO QPM	_____ weeks	4 Week Supply	_____
☐ Other: _____	_____	_____	_____ weeks	_____	_____

PRESCRIBER INFORMATION

PREFERRED CONTACT METHOD: ☐ Phone ☐ Fax ☐ Email

Prescriber Name	Type: ☐ MD/DO ☐ Nurse Practitioner ☐ Physician's Assistant		
Office Contact	Supervising Prescriber (if applicable)		
Phone #	Fax #	Email	
Address	City	State	Zip
NPI	DEA		

Your signature authorizes the pharmacy and its representatives to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients. A generically equivalent drug product may be dispensed unless the prescriber writes "Brand Necessary" or "Brand Medically Necessary" on the face of the prescription. PRXP can only accept faxed prescriptions from a prescriber's office or original prescriptions from patients.

_____ *Prescriber Signature*

_____ *Date*

*Licensed in NY, NJ, and CT.