ADDRESS: 12144 DAIRY ASHFORD RD. SUITE 100 SUGAR LAND, TX 77478

DELIVERIT
Infusion & Specialty

PHONE: (832) 939-8137
FAX: (832) 939-8128

HEPATOLOGY ENROLLMENT FORM

☐ **Infused at MDO.**

☐ **Infused at Home.** SET UP OF SKILLED NURSING VISITS REQUIRED.

COMPLETE PATIENT DEMOGRAPHIC INFORMATION IN SECTION BELOW

Or Attach Face Sheet from Patient Chart

Patient Name:		DOB:	Gender: ☐Male ☐Female	Weight:	☐lbs ☐kg
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip code :	

COMPLETE PATIENT INSURANCE INFORMATION IN THE SECTION BELOW

Or Attach Copies of Patient's Insurance Card

Primary insurance Carrier:	Name of the Insured:	Relationship:
Member ID #:	Group #:	Insurance Phone #:
Secondary Rx Carrier Name:	Rx ID #:	Rx Group #:

PRESCRIPTION INFORMATION

(Check any that apply)

STATEMENT OF MEDICAL NECESSITY

Diagnosis:

☐ B18.2 Hepatitis C ☐ Other ICD 10 _____ ☐ Initial Therapy ☐ Previous Therapy **Genotype:** ☐1 ☐2 ☐3 ☐4 Other Subtype: ☐a ☐b

☐ HCV RNA Level _____ ☐ Treatment Naive ☐ Previous Treatment _____ Date _____

Prior treatment (Duration): From _____ To _____ Total of _____ Weeks ☐ Co-infection ☐ HIV ☐ HBV

Cirrhosis: ☐ Compensated ☐ De- Compensated ☐ Hepatocellular Carcinoma ☐ HIV Status ☐ Post-Liver Transplant

Fibroscan: ☐ Yes ☐ No Score: _____ **History of Liver biopsy?** ☐ Yes ☐ No ☐ N/A **Fibrosis:** ☐ Yes ☐ No ☐ F1 ☐ F2 ☐ F3 ☐ F4

DRUGS	DIRECTION	QUANTITY	REFILLS
☐ MAVYRET* (Glecaprevir/Pibretasvir) 100/40mg	Take 3 tablets by mouth ONCE daily with meals.	28 Packs (84 Tablets)	_____
☐ VOSEVI* (Sofosbuvir/Velpatasvir & Voxilaprevir)	Take 1 TABLET by mouth ONCE a day with meals.	28 Tablets	_____
☐ EPCLUSA* (Sofosbuvir/Velpatasvir) 400/100mg	Take 1 TABLET by mouth ONCE a day with or without meals.	28 Tablets	_____
☐ HARVONI* (Ledipasvir/Sofosbuvir) 90/400mg	Take 1 TABLET by mouth ONCE a day with or without meals.	28 Tablets	_____
☐ ZEPATIER* (Elbasvir/Grazoprevir) 50/100mg	Take 1 TABLET by mouth ONCE a day with or without meals.	28 Tablets	_____
☐ DAKLINZA 30MG* ☐ DAKLINZA 60MG* (Daclatasvir)	Take 1 TABLET by mouth ONCE a day with or without meals.	28 Tablets	_____
☐ VIEKIRA XR* (Paritaprevir/Ombitasvir/Ritonavir & Dasabuvir)	Take 3 TABLETS by mouth once daily.	28 Packs (84 Tablets)	_____
☐ VIEKIRA PAK* (Ombitasvir/Paritaprevir/Ritonavir & Dasabuvir)	Take TWO TABLETS of ombitasvir/paritaprevir/ritonavir and ONE TABLET of dasabuvir in the morning. Take ONE TABLET of dasabuvir in the evening.	4 Packs (112 Tablets)	_____
☐ SOVALDI* (Sofosbuvir) 400mg	Take 1 TABLET by mouth ONCE a day with or without meals.	28 Tablets	_____
☐ TECHNIVIE* (Ombitasvir/Paritaprevir/Ritonavir)	Take 2 tablets (One Pack) by mouth ONCE a day.	28 Packs (84 Tablets)	_____
☐ RIBAPAK* ☐ MODERIBA* (Ribavirin)	☐ 600mg ☐ 800mg ☐ 1000mg ☐ 1200mg ☐ Take _____ mg in the morning _____ mg in the evening	28 days supply	_____

HEPATITIS B TREATMENT

☐ **BARACLUDE** ☐ 0.5mg Tablet ☐ 1mg Tablet ☐ 0.5mg/mL Solution ☐ **VIREAD** ☐ 150mg ☐ 200mg ☐ 300mg ☐ **VEMLIDY** ☐ 25mg

Directions: _____ Qty: _____ Refill: _____ Directions: _____ Qty: _____ Refill: _____

COMPLETE PRESCRIBER INFORMATION IN SECTION BELOW

Prescriber Name:	NPI#:	Office#:	Fax#:
Address:	City:	State:	Zipcode:

SIGNATURE OF LICENSED PRESCRIBER (REQUIRED TO VALIDATE PRESCRIPTION)

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

Prescriber's Signature:

X_____

☐ DAW(Dispense as Written) Date: _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. No stamped signatures will be accepted. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.