

Need By Date: ____ / ____ / ____

SHIP TO: Office Patient Patient pick-up in pharmacy

PATIENT INFO

PROVIDER INFO

Name: _____ Address: _____ City: _____ State: _____ ZIP: _____
 Phone: _____ Alt Phone: _____ SSN: _____ DOB: _____
 Height: _____ Weight: _____ Alt. Contact: _____ Phone: _____

Name: _____ Address: _____ City: _____ State: _____ ZIP: _____
 Phone: _____ Alt Phone: _____ NPI: _____ DEA: _____
 License #: _____ Contact: _____ Phone #: _____

PLEASE FAX A COPY OF THE PATIENT'S PRESCRIPTION CARD AND MEDICAL CARD FRONT AND BACK

Diagnosis/Clinical Information | Please FAX recent clinical notes, labs and tests with the prescription to expedite the prior authorization

Select Diagnosis Code (ICD-10): B18.2 Chronic Hepatitis Other: _____
 List patient medication allergies: _____

**PRESCRIPTION INFORMATION (TREATMENT-NAIVE OPTIONS)
 (BRANDED ENROLLMENT FORM USE PROHIBITED IN ARIZONA, VIRGINIA AND WEST VIRGINIA)**

Medication	Dosage & Strength	Directions	Qty	Refills
<input type="checkbox"/> MAVYRET® (glecaprevir and pibrentasvir)	100 mg/ 40mg tablet	Take 3 tablets by mouth daily with food Note: Treatment duration for NO cirrhosis is 8 weeks. Treatment duration WITH cirrhosis is 12 weeks	84	____
<input type="checkbox"/> EPCLUSA® (sofosbuvir and velpatasvir)	400 mg/ 100mg tablet	Take 1 tablet by mouth daily with or without food Note: Treatment duration WITH OR WITHOUT cirrhosis is 12 weeks Add ribavirin for Child Pugh Class B-C; decompensated cirrhosis	28	2
<input type="checkbox"/> HARVONI® (ledipasvir and sofosbuvir)	400 mg/ 90mg tablet	Take 1 tablet by mouth daily with or without food Note: Treatment duration WITH OR WITHOUT cirrhosis is 12 weeks May consider 8 weeks of treatment if treatment-naive, genotype 1, no cirrhosis, no HIV and baseline HCV load is < 6 million	28	____
<input type="checkbox"/> ZEPATIER® (elbasvir and grazoprevir)	100 mg/ 50mg tablet	Take 1 tablet by mouth daily with or without food Note: Treatment duration WITH OR WITHOUT cirrhosis is 12 weeks	28	2

Prescriber Authorization: I hereby authorize St. Matthews Specialty Pharmacy to complete and submit prior authorization ("PA") requests to payors for the prescribed medication for this patient, to attach supporting documentation provided by my office, and to attach this form to the PA request as my signature. For Arizona, Virginia and West Virginia only: I understand that use of prescription order-blank that refers to a specific pharmacy is prohibited and enrollment forms received with such information for Arizona, Virginia and West Virginia residents will be considered null and void.

Prescriber's Signature: _____ Date: ____ / ____ / ____

Patient Authorization: I authorize St. Matthews Specialty Pharmacy to bill my insurance company for this prescription and refills of this prescription. I understand that I am financially responsible for any co-pay / co-insurance amounts or other amounts not covered by my insurance. I understand that either I or my authorized representative will need to contact St. Matthews Specialty Pharmacy if there are changes in my insurance or I no longer need this prescription.

I authorize St. Matthews Specialty Pharmacy to disclose protected health information to third parties, including insurance carriers, pharmacy benefit managers, pharmaceutical manufacturers, or their agents, as necessary to secure PA for the prescribed medication.

I allow my prescriber to be my authorized individual and may order my prescription refills / schedule delivery or pickup of my prescription.

I understand I have an offer for prescription counseling by the pharmacist and may contact the pharmacy for such counseling in the future but decline the offer of counseling at this time.

Patient's Signature: _____ Date: ____ / ____ / ____

Important Notice: This fax is intended only to the named addressee and contains information that may be protected health information under federal and state laws. If you are not the intended recipient, do not copy, distribute, or disseminate. Please notify the sender immediately and destroy this document.