St. Matthews Pharmacy

Fax: 844-524-4673 | Phone: 844-690-4462

HEPATITIS C FORM

Need By Date: ____/____/____ SHIP TO: ☐ Office ☐ Patient ☐ Patient pick-up in pharmacy

PATIENT INFO

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Alt Phone: _____

SSN: _____ DOB: _____

Height: _____ Weight: _____

Alt. Contact: _____ Phone: _____

PROVIDER INFO

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
☐ **MAVYRET®** (glecaprevir and pibrentasvir)	100 mg/ 40mg tablet	Take 3 tablets by mouth daily with food **Note**: Treatment duration WITH OR WITHOUT cirrhosis is 8 weeks	84	1
☐ **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
☐ **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	____
☐ **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 **initiate** 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.

Revised 10/2024