Optum Specialty Phone: 855-427-4682
Optum Specialty Fax: 877-342-4596

Hepatitis C Enrollment Form

Specialty Pharmacy Enrollment Form — Please detach before submitting to a pharmacy – tear here. — **This form is not a valid prescription in Arizona** or Virginia

PATIENT INFORMATION

Please complete the following or ***send patient demographic sheet***

Patient Name ______

DOB ______ Last Four of SS# ______ Gender ______

Weight ______ Height ______ Phone ______

Address ______

City, State, ZIP ______

Language Preference: ☐ English ☐ Spanish ☐ Other ______

PRESCRIBER INFORMATION

Prescriber's Name ______

DEA ______ NPI ______

Group/Hospital ______

Address ______

City, State, ZIP ______

Phone ______ Fax ______

Contact Person ______ Phone ______

INSURANCE INFORMATION *(Must fax a copy of patient's insurance card including both sides)*

Prior Authorization Reference number ______

MEDICAL INFORMATION *(Section must be completed to process prescription)* (Attach separate sheet if needed)

☐ B18.2 Chronic Hepatitis C ☐ K72.90 Hepatic failure, unspecified without coma ☐ C22.0 Liver Cell Carcinoma

☐ Other Diagnosis: ICD-10 Code ______ Description ______

Genotype ______ Viral Load ______ IU/ml Viral Load Date ______ HIV Coinfected: ☐ Yes ☐ No HBV Coinfected: ☐ Yes ☐ No

Previous therapy history: Naïve ______ Relapsed ______ Partial Responder ______ Null ______

Date(s) of previous therapy and meds ______

Cirrhosis: ☐ Yes ☐ No ☐ Compensated OR ☐ Decompensated Fibrosis Score ______

Liver Transplant: ☐ Yes ☐ No Waiting for Liver Transplant: ☐ Yes ☐ No

Please include hard copies of: genotype, viral load, liver fibrosis staging, CBC, CMP, HIV, HBsAb, HBsAg, HBcAb, PT/INR, H&P, and pertinent office visit notes.

PRESCRIPTION INFORMATION

☐ EPCLUSA (sofosbuvir 400mg/velpatasvir 100mg) disp. 28 Sig: 1 tablet daily Refill: x ______ Total duration of therapy ______ Weeks

☐ HARVONI® (ledipasvir 90mg/sofosbuvir 400mg) disp. 28 Sig: 1 tablet daily Refill: x ______ Total duration of therapy ______ Weeks

☐ MAVYRET™ (glecaprevir 100mg/pibrentasvir 40mg) disp 84 Refill: x ______ Total duration of therapy ______ Weeks
Sig: Take 3 tablets (contents of one daily dose card) by mouth once daily with food.

☐ Other: ______ disp ______ Sig: ______ Refill: x ______ Total duration of therapy ______ Weeks

RIBAVIRIN 200mg (28 day supply):
☐ < 75kg = 1000mg/day ☐ 1200mg daily/600mg QAM—600mg QPM ☐ 800mg daily/400mg QAM—400mg QPM
☐ ≥ 75kg = 1200mg/day ☐ 1000mg daily/600mg QAM—400mg QPM ☐ 600mg daily/200mg QAM—400mg QPM
Refill: x ______ Total duration of therapy ______ Weeks

☐ **SOVALDI™** (sofosbuvir) 400mg disp. 28 Sig: 400mg daily Refill: x ______ Total duration of therapy ______ Weeks

☐ **VOSEVI** Disp. 28 day supply Sig: Take once daily with food Refill: x ______ Total duration of therapy ______ Weeks

☐ **ZEPATIER** (elbasvir 50mg/grazoprevir 100mg) disp. 28 Refill: x ______ duration of therapy ______ Weeks
Sig: Take 1 tablet daily with or without food. ☐ NS5A resistance testing included

**Prescriber Authorization:* I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature ______ Date ______ Supervising Physician Signature: ______ Date ______
Electronic or digital signatures not accepted.

**Patient authorization:* I authorize Optum Specialty Pharmacy to immediately arrange for my doctor's office to accept delivery of the first fill of my Hepatitis C prescription if the out of pocket cost does not exceed $20.00. I understand I will be invoiced for that amount at a later date. For future fills, I authorize Optum Specialty Pharmacy to arrange for my doctor's office to accept delivery of my Hepatitis C prescription and charge the out of pocket amount to the credit/debit card I place on file. I understand that if I do not store a card on file and the cost exceeds $20.00, Optum Specialty Pharmacy will contact me for payment before my order ships, which may delay my orders, if Optum Specialty Pharmacy is unable to reach me. I understand that this consent will be valid for the duration of my benefit year and this treatment and that if I no longer want Optum Specialty Pharmacy to charge my debit/credit card on file and ship to my doctor's office without contacting me before each shipment, I must call Optum Specialty Pharmacy to cancel this consent. I understand that failure to cancel consent will result in costs until I cancel my consent.

Ship to: ☐ Patient ☐ Office First Fill (future fills to Patient) ☐ Office ALL fills ☐ Other ______ Date ______ Needs by Date ______

Patient Signature ______ Date ______
Electronic or digital signatures not accepted.

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. This form is not a valid prescription in Arizona or Virginia.