



Hepatitis Patient Enrollment and Prescription Form

Tel: 844-443-6879 Fax: 844-329-2447 ePrescribe to our pharmacy at "GENTRY HEALTH SERVICES" in Avon Lake, Ohio.

PATIENT INFORMATION

Patient Name _____
 DOB ___/___/___ SSN _____ Gender _____
 Weight _____ Height _____ Phone _____
 Address _____
 City, State, Zip _____
 Cell Phone _____ E-Mail _____
PLEASE PROVIDE COPY OF PATIENT'S PRESCRIPTION INSURANCE CARD WITH ENROLLMENT FORM
 Insurance Co. Name _____
 Insurance Co. Phone _____ Group# _____
 Policy Holder Name _____
 Policy Holder Employer _____
 Relationship to Patient _____
 ID# _____ RxBIN _____ PCN _____

PRESCRIBER INFORMATION

Prescriber's Name _____
 Practice Name _____
 DEA _____ NPI _____
 Address _____
 City, State, Zip _____
 Phone _____ Fax _____
 Office Contact Person _____
 Office Contact EMAIL _____
 Prescription Date _____ Date Needed _____

With my signature on this form, I also authorize use of Gentry Health's Services which includes serving as my prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.
Prescriber Signature _____

Ship to: Patient Prescriber's Office Discount Drug Mart

PLEASE PROVIDE ALL RELEVANT CHART NOTES FOR INSURANCE PURPOSES

Medical Information (DO NOT COMPLETE IF CHART NOTES ARE PROVIDED)

Diagnosis _____ ICD-10 Code _____
 Genotype _____ If Genotype 1a, NS5A Resistance Associated Polymorphism? YES NO Q80K Test? YES NO
 Viral Load (IU/ml) _____ Date Measured _____ HIV Positive? _____ YES _____ NO
 Liver Biopsy Completed? YES NO If so, Fibrosis Grading Score (Ishak or METAVIR) _____
 Creatinine Level _____ ALT _____ AST _____ Bilirubin _____ Date Measured _____
 Hemoglobin Level _____ Neutrophil Count _____ Platelet Count _____ Date Measured _____
 Drug Allergies _____ Latex Allergy _____ YES _____ NO
 Other Disease States or Comorbidities _____
 Any previous treatment? YES NO Date and previous medications used _____

PRESCRIPTION INFORMATION

DAKLINZA™ (daclatasvir) Tabs 30mg 60mg
 Directions: Take orally once daily with/without food in combination with sofosbuvir Quantity _____ Refills _____

EPCLUSA® (100mg velpatasvir and 400mg sofosbuvir)
 Directions: Take one tablet orally once daily with or without food Quantity _____ Refills _____

HARVONI® (90mg ledipasvir and 400mg sofosbuvir)
 Directions: Take one tablet orally once daily with or without food Quantity _____ Refills _____

MAVYRET™ (100mg glecaprevir and 40MG pibrentasvir)
 Directions: Three tablets taken orally once daily with food. Quantity _____ Refills _____

OLYSIO® (simeprevir) 150mg Caps
 Directions: _____ Quantity _____ Refills _____

SOVALDI® (sofosbuvir) 400mg Tabs
 Directions: Take one tablet orally once daily with or without food Quantity _____ Refills _____

VIEKIRA PAK™ (25mg ombitasvir, 150mg paritaprevir, 100mg ritonavir and 500mg dasabuvir)
 Directions: Take the 2 pink tablets with 1 of the beige tablets at about the same time every morning with a meal. Take the second beige tablet at about the same time every evening with a meal. Quantity _____ Refills _____

VIEKIRA XR™ (25mg ombitasvir, 150mg paritaprevir, 100mg ritonavir and 600mg dasabuvir)
 Directions: Take 3 tablets once daily with a meal (Swallow tablet whole). Quantity _____ Refills _____

VOSEVI™ (100 mg velpatasvir, 400 mg sofosbuvir and 100 mg voxilaprevir)
 Directions: Take 1 tablet once daily with a meal (Swallow tablet whole). Quantity _____ Refills _____

ZEPATIER™ (100mg grazoprevir and 50mg elbasvir)
 Directions: One tablet taken orally once daily with or without food. Quantity _____ Refills _____

Ribavirin Ribavirin 200mg **CAP** Ribavirin 200mg **TAB**
 Directions: _____ Quantity _____ Refills _____

CONFIDENTIALITY NOTICE: THE INFORMATION IN THIS TRANSMITTAL IS CONFIDENTIAL AND INTENDED ONLY FOR THE RECIPIENT LISTED ABOVE. IF YOU ARE NEITHER THE INTENDED RECIPIENT NOR A PERSON RESPONSIBLE FOR DELIVERING THIS TRANSMITTAL TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISTRIBUTION OR COPYING OF THIS TRANSMITTAL IS PROHIBITED. IF YOU RECEIVE THIS TRANSMITTAL IN ERROR, PLEASE IMMEDIATELY NOTIFY US AND RETURN THE TRANSMITTAL TO US AT OUR EXPENSE.