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

ATTACH MOST RECENT CMP, CBC AND LFT RESULTS

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 Fibrosis Grading Score ☐F0 ☐F1 ☐F2 ☐F3 ☐F4

Drug Allergies _____ Latex Allergy _____ YES _____ NO

Other Disease States or Comorbities _____

Any previous treatment? ☐YES ☐NO Date and previous medications used _____

PRESCRIPTION INFORMATION

☐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 _____

☐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 _____