Dolphin Health Rx
Committed to Helping People Get Well

HEPATITIS C ENROLLMENT & RX FORM

Toll Free: 844-436-5744
Local Phone: 510-900-3131
Fax: 844-329-6979

PATIENT INFORMATION

Today's Date:
Need By Date:
Training by:
☐ Pharmacy ☐ Provider
☐ Other: _____
Ship To:
☐ Patient ☐ Provider
☐ Other: _____

Patient Name:
Date of Birth:
SSN:
Address:
City, State, Zip Code:
Phone:
Email Address:
Preferred language:
Contact Person:

ENROLLMENT CHECKLIST

PLEASE ORDER FOR ALL PATIENTS

- ☐ Demographics
- ☐ Insurance cards
- ☐ Last 2 visit notes
- ☐ HCV Genotype
- ☐ HCV RNA (Last 90 days)
- ☐ Current Med List
- ☐ Fibrosis documentation (Biopsy, Fibroscan, Fibrosure)
- ☐ CBC with platelets
- ☐ Complete Metabolic Panel
- ☐ Imaging (*if available)
- ☐ PT/INR (*if cirrhotic)
- ☐ Pt adherence/readiness documentation

DIAGNOSIS INFORMATION (Please include supporting documents)

Diagnosis:
- ☐ 070.54 Hepatitis C
- ☐ HCV/HIV Co-infection
- ☐ HCV/HBV Co-infection
- ☐ HCC
- ☐ Pre/post- transplant

Height: _____
Weight: _____

Genotype:
☐ 1A ☐ 4
☐ 1B ☐ 5
☐ 2 ☐ 6
☐ 3
☐ Other: _____

Allergies: _____

Prior treatment history:
☐ Naïve ☐ Relapser ☐ Non-Responder
☐ Discontinued due to side effects

Prior treatment regimen:
☐ RBV ☐ IFN ☐ Harvoni ☐ Sovaldi
☐ Olysio ☐ Incivek ☐ Victrelis ☐ Other: _____

Stage of Fibrosis
☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4 APRI score: _____

HIGH PRIORITY FOR TREATMENT

(Please select all that apply)
Please include labs and/or notes

COMORBIDITIES
- ☐ HIV co-infection
- ☐ HBV co-infection
- ☐ Type 2 DM
- ☐ Debilitating fatigue

EXTRAHEPATIC MANIFESTATIONS
- ☐ Porphyria cutanea carda
- ☐ Symptomatic cryoglobulinemia
- ☐ HCV-related kidney disease

ELEVATED RISK OF HCV TRANSMISSION
- ☐ MSM w/ high risk sexual practices
- ☐ Active IVDU
- ☐ Long-term HD
- ☐ Women of child-bearing potential wishing to get pregnant
- ☐ HCV infected Healthcare worker who performs exposure prone procedures

CURRENT TREATMENT REGIMENS (*= off label use; however regimen is recommended by AASLD as of 7/27/15)

Genotype	Available Regimens	Duration	Notes
Genotype 1	**Harvoni**	8 weeks	8 wks =Tx naïve, w/o cirrhosis, baseline VL < 6 million
		12 weeks	12 wks = Tx naïve w/cirrhosis & tx experienced w/o cirrhosis
		24 weeks	24 wks = Tx experienced w/ cirrhosis
	Viekira Pak	12 weeks	GT 1b w/o cirrhosis
	Viekira Pak + RBV	12 weeks	GT 1a w/o cirrhosis OR GT 1b w/cirrhosis
	Viekira Pak + RBV	24 weeks	GT 1a w/cirrhosis
	Sovaldi + Olysio	12 weeks	Tx naïve & experienced w/o cirrhosis
	Sovaldi + Olysio	24 weeks	Tx naïve & experienced w/ cirrhosis
Retreatment	***Harvoni + RBV**	12 weeks	SOF-failure w/o cirrhosis
	***Harvoni + RBV**	24 weeks	SOF-failure w/ cirrhosis
Genotype 2	**Sovaldi + RBV**	12-16 weeks	*16 weeks = cirrhotic pts
Genotype 3	**Sovaldi + Daklinza**	12 weeks	
	Sovaldi + RBV + IFN	12 weeks	
	Sovaldi + RBV	24 weeks	24 weeks = IFN - ineligible
Genotype 4	**Technivie + RBV**	12 weeks	Non-cirrhotic
	Technivie	12 weeks	Tx naïve, non-cirrhotic, who cannot take ribavirin
	Sovaldi + RBV	24 weeks	
	Sovaldi + RBV + IFN	12 weeks	
	***Harvoni**	12 weeks	
	***Sovaldi + Olysio**	12 weeks	
Genotype 5 + 6	***Harvoni**	12 weeks	
	***Sovaldi + IFN + RBV**	12 weeks	

TREATMENT REGIMEN & PRESCRIPTION

	MEDICATION	STRENGTH	DIRECTIONS	DISPENSE QTY	DURATION
NS5A/NS5B Inhibitor	☐ **HARVONI®** sofosbuvir/ledipasvir	90/400mg	Take 1 tablet by mouth once daily	☐ Up to 30 days ☐ Up to 90 days	
3D Combination	☐ **VIEKIRA PAK™**	25/150/100/250 mg	Ombitasvir/Paritaprevir/Ritonavir QD Plus Dasabuvir BID	☐ Up to 30 days ☐ Up to 90 days	
POLYMERASE INHIBITORS	☐ **SOVALDI™** (sofosbuvir)	400mg	Take 1 tablet by mouth once daily	☐ Up to 30 days ☐ Up to 90 days	
NS5A INHIBITOR	☐ **DAKLINZA™**	☐ 30mg ☐ 60mg (normal dosage) ☐ 90mg	Take one tablet by mouth once daily with sofosbuvir	☐ Up to 30 days ☐ Up to 90 days	
PROTEASE INHIBITORS	☐ **OLYSIO™** (simeprevir)	150mg	Take 1 capsule by mouth once daily with food	☐ Up to 30 days ☐ Up to 90 days	
Combination	☐ **TECHNIVIE™**	12.5/75/50 mg	Take 2 tablets by mouth once daily with food	☐ Up to 30 days ☐ Up to 90 days	
RIBAVIRIN	☐ **RIBAPAK®** ☐ DAW1 (or ribavirin equivalent) ☐ _____	☐ 600mg ☐ 800mg ☐ 1000mg (≤75kg) ☐ 1200mg (>75kg) ☐ 1400mg ☐ _____	400mg QAM, 200mg QPM, with food 400mg QAM, 400mg QPM, with food 600mg QAM, 400mg QPM, with food 600mg QAM, 600mg QPM, with food 800mg QAM, 600mg QPM, with food _____	☐ Up to 30 days ☐ Up to 90 days	
OTHER	☐ _____	☐ _____		☐ Up to 30 days ☐ Up to 90 days	

PROVIDER AUTHORIZATION & INFORMATION

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to Dolphin Health to act as the prescriber's agent to begin and To execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Name: _____ Address: _____
DEA: _____ NPI: _____ City, State, ZIP Code: _____
Phone: _____ Fax: _____ Contact Person: _____

Date: _____ **Provider Signature:** _____ ☐ **Do not substitute**