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

Written Date:

Ship To:
- ☐ Patient (All Fills)
- ☐ Provider (1st Fill Only)
- ☐ Provider (All Fills)
- ☐ Other: _____

Patient Name:	
Date of Birth:	Gender: ☐ M ☐ F
Height:	Weight:
SSN:	
Address:	
City, State, Zip Code:	
Phone:	
Ethnicity:	
Preferred Language:	
Alternative Contact:	

ENROLLMENT CHECKLIST

PLEASE PROVIDE FOR ALL PATIENTS

- ☐ Demographics
- ☐ Insurance cards
- ☐ Last 2 visit notes
- ☐ HCV Genotype
- ☐ HCV RNA (Last 90 days)
- ☐ CBC w/ PLT (Last 90 days)
- ☐ Complete Metabolic Panel (Last 90 days)
- ☐ Fibrosis documentation (Biopsy, Fibroscan, Fibrosure)
- ☐ Imaging (*if available)
- ☐ PT/INR (*if cirrhotic)
- ☐ NS5A Resistance Testing for GT1a and GT3
- ☐ Current Med List
- ☐ Pt adherence/readiness documentation

DIAGNOSIS INFORMATION (Please include supporting documents)

Diagnosis:
- ☐ B18.2 Chronic Hepatitis C
- ☐ HCV/ HIV Co-infection
- ☐ HCV/ HBV Co-infection
- ☐ HCC
- ☐ Pre/post-transplant

Allergies:
- ☐ NKDA
- ☐ Allergies: _____

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

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

Cirrhosis:
☐ None ☐ Compensated ☐ Decompensated (CTP B or C)

Prior Treatment History: ☐ Naive ☐ Experienced

Previous Regimen	Dates	Response
		☐ R ☐ NR ☐ DC ☐ Other: _____
		☐ R ☐ NR ☐ DC ☐ Other: _____
		☐ R ☐ NR ☐ DC ☐ Other: _____

R= Relapsed NR= Non-responder DC= Discontinued due to side effects

Concomitant Medications: _____

HIGH PRIORITY FOR TREATMENT

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

COMORBIDITIES
- ☐ 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

TREATMENT REGIMEN & PRESCRIPTION

MEDICATION	STRENGTH	DIRECTIONS	DURATION	QUANTITY	REFILL
☐ DAKLINZA™	☐ 30mg ☐ 60mg (normal dose) ☐ 90mg	Take 1 tablet by mouth once daily with Sovaldi	☐ 12 Weeks ☐ 24 Weeks	☐ 28 Tablets	
☐ EPCLUSA®	400/100mg	Take 1 tablet by mouth once daily	☐ 12 Weeks ☐ 24 Weeks	☐ 28 Tablets	
☐ HARVONI®	90/400mg	Take 1 tablet by mouth once daily	☐ 8 Weeks (**non-black, non-HIV co-infected, VL < 6 million IU/mL) ☐ 12 Weeks ☐ 24 Weeks	☐ 28 Tablets	
☐ MAVYRET™	100/40 mg	Take 3 tablets by mouth once daily with food	☐ 8 Weeks ☐ 12 Weeks ☐ 16 Weeks	☐ 84 Tablets	
☐ SOVALDI™	400mg	Take 1 tablet by mouth once daily	☐ 12 Weeks ☐ 24 Weeks	☐ 28 Tablets	
☐ VIEKIRA XR™	200/8.33/50/33.33mg	Take 3 tablets by mouth once daily with food	☐ 12 Weeks ☐ 24 Weeks	☐ 84 Tablets	
☐ VOSEVI™	400/100/100mg	Take 1 tablet by mouth once daily with food	☐ 12 Weeks	☐ 28 Tablets	
☐ ZEPATIER™	50/100mg	Take 1 tablet by mouth daily	☐ 12 Weeks ☐ 16 Weeks	☐ 28 Tablets	
☐ 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	☐ 12 Weeks ☐ 24 Weeks	☐ 56 Tablets	
☐ Ribasphere® Tablets				☐ ___ x 200mg tablets	
☐ _____	_____	_____	_____	_____	

PROVIDER AUTHORIZATION & INFORMATION

By signing below, the prescriber gives consent to the following: the prescription(s) above, 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**

Updated 8/17/2017