MEDICAL PARK Rx
Specialty Services

HEPATITIS C VIRUS SPECIALTY CARE PROGRAM

Phone: **844-418-9857** • Fax: **888-933-5554**

KLOUDSCRIPT
Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: ❍ M ❍ F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Diagnostic Information

Date of Diagnosis: _____ ICD-10: _____ Other: _____
Genotype: _____ Subtype: _____ Q80K: ❑ Positive ❑ Negative (For Genotype 1a)
Indicate Patient Status: ❑ Naïve ❑ Partial Responder ❑ Non-responder ❑ Null-responder ❑ Relapser
Duration of Previous Therapy: _____ Weeks From: _____ To: _____
Cirrhosis: ❑ No ❑ Yes If Yes: ❑ Compensated ❑ Decompensated
History of Liver Biopsy? ❑ No ❑ Yes If Yes, Please Attach Results
❑ Fibrosure or ❑ Fibroscan: Results: _____
Extra-Hepatic Manifestations: ❑ Ascites ❑ Hepatic Encephalopathy ❑ Thrombocytopenia
❑ Other: _____
Does the patient need liver transplantation? ❑ Yes ❑ No

If Prior Authorization is Denied:
❑ Automatically Draft Appeal for Review ❑ Send Formulary Preferred Alternatives

Labs

ALT: _____ HGB: _____
AST: _____ HCV RNA: _____
PLT: _____ SrCr: _____
Date: _____

Medication List and Contraindications

❑ Attach Medication List
Is the patient interferon ineligible? ❑ No ❑ Yes
❑ Anxiety ❑ Depression ❑ Pulmonary Abnormalities
❑ Renal Insufficiency ❑ Other: _____

4 PRESCRIPTION INFORMATION: Duration of Therapy: ❑ 8 Weeks ❑ 12 Weeks ❑ 24 Weeks ❑ Other _____

Medication	Dosage & Strength	Direction	QTY	Refills
❑ DAKLINZA™	❑ 30mg Tablets ❑ 60mg Tablets	❑ Take 30mg daily with or without food ❑ Take 60mg daily with or without food ❑ Take 90mg daily with or without food	28 28 84	
❑ HARVONI®	❑ 90mg/400mg Tablet	Take one tablet daily with or without food	28	
❑ OLYSIO™	❑ 150mg Capsules	Take one 150mg capsule orally once a day	28	
❑ SOVALDI®	❑ 400mg Tablets	Take one 400mg tablet orally once a day	28	
❑ TECHNIVIE™	❑ 12.5/75/50mg Tablets	Take two tablets once daily in the morning with a meal	56	
❑ VIEKIRA PAK™	❑ 12.5/75/50mg & 250mg Dose Pack	Take three tablets in the morning and one tablet in the evening with a meal, as directed on the daily dose pack	1 Pack	
❑ ZEPATIER™	❑ 50mg/100mg Tablet	Take one tablet daily with or without food	1 Pack	
❑ MODERIBA Dose Pack™ ❑ RIBASPHERE RibaPack®	❑ 600mg per day ❑ 800mg per day ❑ 1000mg per day ❑ 1200mg per day	❑ Take 200mg tablet every morning/400mg tablet every evening ❑ Take 400mg tablet every morning/400mg tablet every evening ❑ Take 600mg tablet every morning/400mg tablet every evening ❑ Take 600mg tablet every morning/600mg tablet every evening		
❑ MODERIBA™ ❑ RIBASPHERE® ❑ RIBAVIRIN	❑ 200mg Tablets ❑ 200mg Capsules	Take _____ tablets/capsules every morning and, Take _____ tablets/capsules every evening		
❑ XIFAXAN®	❑ 550mg Tablets	Take one tablet twice daily with or without food	60	
❑ _____	_____	_____		

5 INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

6 PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

7 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

8 PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____
Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.