



Phone: 877-358-8893 option 5  
 Fax: 877-480-1748

# Proteus Hepatitis C Prescription Referral Form

Specialty Pharmacy Enrollment Form

Please detach before submitting to a pharmacy – tear here.

## PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name \_\_\_\_\_  
 DOB \_\_\_\_\_ Last Four of SS# \_\_\_\_\_ Gender \_\_\_\_\_  
 Weight \_\_\_\_\_ Height \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, ZIP \_\_\_\_\_  
 Language Preference:  English  Spanish  Other \_\_\_\_\_

## PRESCRIBER INFORMATION

Prescriber's Name \_\_\_\_\_  
 DEA \_\_\_\_\_ NPI \_\_\_\_\_  
 Group/Hospital \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, ZIP \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

## INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number \_\_\_\_\_

## MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

B18.2 Chronic Hepatitis C  K72.90 Hepatic failure, unspecified without coma  C22.0 Liver Cell Carcinoma  
 Other Diagnosis: ICD-10 Code \_\_\_\_\_ Description \_\_\_\_\_  
 Genotype \_\_\_\_\_ Viral Load \_\_\_\_\_ IU/ml Viral Load Date \_\_\_\_\_ HIV Coinfected:  Yes  No HBV Coinfected:  Yes  No  
 Previous therapy history: Naïve \_\_\_\_\_ Relapsed \_\_\_\_\_ Partial Responder \_\_\_\_\_ Null \_\_\_\_\_  
 Date(s) of previous therapy and meds \_\_\_\_\_  
 Cirrhosis:  Yes  No  Compensated OR  Decompensated Fibrosis Score \_\_\_\_\_  
 Liver Transplant:  Yes  No Waiting for Liver Transplant:  Yes  No Allergies: \_\_\_\_\_

Please include hard copies of: genotype, viral load, liver biopsy scans, CBC, CMP, HIV, PT/INR, H&P, NS5A resistance testing and pertinent office visit notes.

## PROTEUS Prescription Information

Medication	Dose / Strength	Directions	Quantity	Refills
<input type="checkbox"/> Epclusa® (sofosbuvir/velpatasvir)	<input type="checkbox"/> 400mg/100mg	Take 1 Capsule by mouth daily, with or without food. Each capsule contains 1 Epclusa and 2 Proteus ingestible sensors	28 day supply	
<input type="checkbox"/> Harvoni® (ledipasvir/sofosbuvir)	<input type="checkbox"/> 90mg/400mg	Take 1 Capsule by mouth daily, with or without food. Each capsule contains 1 Harvoni and 2 Proteus ingestible sensors	28 day supply	
<input type="checkbox"/> Mavyret® (glecaprevir/pibrentasvir)	<input type="checkbox"/> 100mg/40mg	Take 3 Capsules by mouth daily, with food. Each capsule contains 1 Mavyret and 2 Proteus ingestible sensors	28 day supply	
<input type="checkbox"/> Proteus Adhesive Strips	6 Per Box	Apply to skin weekly or as directed	1 box	PRN
<input type="checkbox"/> Proteus Data Pod	1 Per Box	Spare Data Pod. Contact Proteus Support before using (855-255-5858)	1 box	PRN
<input type="checkbox"/> Proteus Starter Kit BYOD		Use Kit for Onboarding	1	
<input type="checkbox"/> Additional Notes				
<input type="checkbox"/>				

Ship to:  Patient  Office First Fill  Office ALL fills  Other \_\_\_\_\_ Date \_\_\_\_\_ Needs by Date \_\_\_\_\_  
 (future fills to Patient)

Product Substitution permitted  Dispense as Written

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_ Supervising Physician Signature: \_\_\_\_\_ Date \_\_\_\_\_

Electronic or digital signatures not accepted.

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