



Optum Specialty Phone: 855-427-4682
Optum Specialty Fax: 877-342-4596

Hepatitis C Enrollment 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

Please include hard copies of: genotype, viral load, liver fibrosis staging, CBC, CMP, HIV, HBsAb, HBsAg, HbCAb, PT/INR, H&P, and pertinent office visit notes.

PRESCRIPTION INFORMATION

EPCLUSA (sofosbuvir 400mg/velpatasvir 100mg) disp. 28 Sig: 1 tablet daily Refill: x _____ Total duration of therapy _____ Weeks
 HARVONI® (ledipasvir 90mg/sofosbuvir 400mg) disp. 28 Sig: 1 tablet daily Refill: x _____ Total duration of therapy _____ Weeks
 MAVYRET™ (glecaprevir 100mg/pibrentasvir 40mg) disp 84 Refill: x _____ Total duration of therapy _____ Weeks
Sig: Take 3 tablets (contents of one daily dose card) by mouth once daily with food.
 Other: _____ disp _____ Sig: _____ Refill: x _____ Total duration of therapy _____ Weeks
RIBAVIRIN 200mg (28 day supply): < 75kg = 1000mg/day 1200mg daily/600mg QAM—600mg QPM 800mg daily/400mg QAM—400mg QPM
 ≥ 75kg = 1200mg/day 1000mg daily/600mg QAM—400mg QPM 600mg daily/200mg QAM—400mg QPM
Refill: x _____ Total duration of therapy _____ Weeks
 SOVALDI™ (sofosbuvir) 400mg disp. 28 Sig: 400mg daily Refill: x _____ Total duration of therapy _____ Weeks
 VOSEVI Disp. 28 day supply Sig: Take once daily with food Refill: x _____ Total duration of therapy _____ Weeks
 ZEPATIER (elbasvir 50mg/grazoprevir 100mg) disp. 28 Refill: x _____ duration of therapy _____ Weeks
Sig: Take 1 tablet daily with or without food. NS5A resistance testing included

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Product Substitution permitted Dispense as Written

Prescriber's Signature _____ Date _____ Supervising Physician Signature: _____ Date _____
Electronic or digital signatures not accepted.

***Patient authorization:** I authorize Optum Specialty Pharmacy to immediately arrange for my doctor's office to accept delivery of the first fill of my Hepatitis C prescription if the out of pocket cost does not exceed \$20.00. I understand I will be invoiced for that amount at a later date. For future fills, I authorize Optum Specialty Pharmacy to arrange for my doctor's office to accept delivery of my Hepatitis C prescription and charge the out of pocket amount to the credit/debit card I place on file. I understand that if I do not store a card on file and the cost exceeds \$20.00, Optum Specialty Pharmacy will contact me for payment before my order ships, which may delay my orders, if Optum Specialty Pharmacy is unable to reach me. I understand that this consent will be valid for the duration of my benefit year and this treatment and that if I no longer want Optum Specialty Pharmacy to charge my debit/credit card on file and ship to my doctor's office without contacting me before each shipment, I must call Optum Specialty Pharmacy to cancel this consent. I understand that failure to cancel consent will result in costs until I cancel my consent.

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

Patient Signature _____ Date _____
Electronic or digital signatures not accepted.

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.