Hepatitis C Enrollment Form

Please fax the completed form to

601-420-4040

Signature Care Program

2506 Lakeland Drive
Flowood, MS 39232
Phone: 866-420-4041
Fax: 601-420-4040
www.transcriptpharmacy.com

Delivery Need By: Delivery to: ☐ Patients Home ☐ Physician's Office ☐ Other

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: ☐ Female ☐ Male	Prescriber Name:
Address:	Address:
City, State, Zip: , ,	City, State, Zip: , ,
Phone:	Phone:
Date of Birth:	Fax:
Social Security Number:	DEA/NPI#:

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis:	Has the patient been treated previously for this condition? ☐ Yes ☐ No
ICD-10 Code: ☐ B17.1 ☐ B17.11 ☐ B17.10 ☐ B18.2 ☐ B19.2 ☐ B19.21 ☐ B19.20 ☐ Z22.52 ☐ Other:	Medications failed:
Height: feet inches Weight: lbs.	Medications on:
Allergies:	Other notes:

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Daklinza™	☐ 30mg tablet ☐ 60mg tablet ☐ 90mg tablet	☐ Specified:	4 week supply	
Epclusa™	400-100mg tablets	☐ Take tablet(s) by mouth times daily	4 week supply	
Harvoni®	90-400mg tablets	☐ Take tablet(s) by mouth times daily	4 week supply	
Mavyret™	100/40 mg	☐ Take capsule(s) by mouth times daily with food	4 week supply	
Olysio™	150mg capsules	☐ Take capsule(s) by mouth times daily	4 week supply	
Ribavirin™	☐ 200mg tablets ☐ 200mg capsules	☐ Take tablet(s) by mouth times daily ☐ Take capsule(s) by mouth times daily	4 week supply	
Sovaldi®	400mg tablets	☐ Take tablet(s) by mouth times daily	4 week supply	
Viekira Pak™	12.5/75/50 – 250mg Dosepack	☐ Take two 12.7/75/50mg tablets by mouth once daily every morning, and one 250mg tablet by mouth twice daily (morning and evening) with meal	4 week supply	
Viekira XR™	8.33/50/33.33 – 200mg Dosepack	☐ Take tablet(s) by mouth times daily	4 week supply	
Vosevi™	400/100/100mg	☐ Take tablet(s) by mouth once daily with food	4 week supply	
Zepatier™	50mg/100mg tablets	☐ One tablet taken orally once daily with or without food	4 week supply	
Other:				

☐ Patient is interested in patient support programs ☐ Ancillary supplies provided for administration

Office Contact Name: _____ Preferred phone number & extension: _____

Physician Signature: _____ Date: _____

E-Scribe Rx and Fax this Form to 601-420-4040