

Hepatitis C Enrollment Form

Please fax the completed form to

601-420-4040



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: <input type="checkbox"/> Female <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
ICD-10 Code: <input type="checkbox"/> B17.1 <input type="checkbox"/> B17.11 <input type="checkbox"/> B17.10 <input type="checkbox"/> B18.2 <input type="checkbox"/> B19.2 <input type="checkbox"/> B19.21 <input type="checkbox"/> B19.20 <input type="checkbox"/> Z22.52 <input type="checkbox"/> Other:	Medications failed:
Height: _____ Weight: _____ feet inches lbs.	Medications on:
Allergies:	Other notes:

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Daklinza™	<input type="checkbox"/> 30mg tablet <input type="checkbox"/> 60mg tablet <input type="checkbox"/> 90mg tablet	<input type="checkbox"/> Specified:	4 week supply	
Eplclusa™	400-100mg tablets	<input type="checkbox"/> Take tablet(s) by mouth times daily	4 week supply	
Harvoni®	90-400mg tablets	<input type="checkbox"/> Take tablet(s) by mouth times daily	4 week supply	
Mavyret™	100/40 mg	<input type="checkbox"/> Take capsule(s) by mouth times daily with food	4 week supply	
Olysio™	150mg capsules	<input type="checkbox"/> Take capsule(s) by mouth times daily	4 week supply	
Ribavirin™	<input type="checkbox"/> 200mg tablets <input type="checkbox"/> 200mg capsules	<input type="checkbox"/> Take tablet(s) by mouth times daily <input type="checkbox"/> Take capsule(s) by mouth times daily	4 week supply	
Sovaldi®	400mg tablets	<input type="checkbox"/> Take tablet(s) by mouth times daily	4 week supply	
Viekira Pak™	12.5/75/50 – 250mg Dosepack	<input type="checkbox"/> 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	<input type="checkbox"/> Take tablet(s) by mouth times daily	4 week supply	
Vosevi™	400/100/100mg	<input type="checkbox"/> Take tablet(s) by mouth once daily with food	4 week supply	
Zepatier™	50mg/100mg tablets	<input type="checkbox"/> 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

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