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Ship To: ☐ Patient ☐ Physician/Clinic Date Shipment Needed: ____________ **Rx:** ☐ New ☐ Refill ____________

PATIENT INFORMATION

Patient's Full Name: ____________
Address: ____________
City, State, Zip: ____________
Home Phone: ____________ Alt. Phone: ____________
Patient SS#: ____________ DOB: ____________
Allergies: ____________
Gender: ☐ Male ☐ Female ☐ See Attached Demographics

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

Primary Insurance: ____________
City: ____________ State: ____________
Plan No: ____________ Group No: ____________
Phone: ____________
Rx Card (PBM): ____________
PBM BIN: ____________
City: ____________ State: ____________
Group: Phone:

DIAGNOSIS INFORMATION

Diagnosis ICD 10: ☐ B18.2 Hepatitis C (Chronic) ☐ Other ____________
Genotype: ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
Baseline Viral Load: ____________ Date: ____________
Degree of fibrosis: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4
Other Fibrosis Score:
Cirrhosis: ☐ none ☐ compensated ☐ decompensated
Transpant status: ☐ N/A ☐ Pre-transplant ☐ Post-transplant
IL28B: ☐ CC ☐ CT ☐ TT

Patient Type:
☐ naive ☐ relapser ☐ partial responder ☐ null responder
Any prior treatment: ☐ No ☐ Yes (provide information below)
Med: From To Weeks
Med: From To Weeks
Med: From To Weeks ____
Co-infection(s) : ☐ None ☐ HIV ☐ HBV
Other Comorbidities:
Allergies: ☐ NKDA ☐ Other

- **Labs:** to be performed prior to therapy and monitored during treatment at appropriate intervals (particularly pregnancy test for woman of childbearing potential)
  ALT ________ AST ________ Hgb ________ Plt ________
- **Other medications** patient is currently taking (including OTC medications):
  ☐ See Med List ____________
- **Other disease states:** ☐ Depression ☐ Anxiety ☐ Diabetes ☐ Other ____________

PRESCRIPTION INFORMATION

☐ **HARVONI®** (Ledipasvir/Sofosbuvir) 90 mg/400 mg tablet QD
Quantity: 28 Refill:
Anticipated duration: ☐ 8 weeks ☐ 12 weeks ☐ 24 weeks ☐ Other ________

☐ **VIEKIRA PAK** (Ombitasvir, paritaprevir, and ritonavir tablets copackaged with dasabuvir tablets)
Take 2 ombitasvir, paritaprevir, ritonavir (pink tablets) once daily (in the morning) and 1 dasabuvir (beige tablet) twice daily (am & pm) with a meal.
Quantity: 112 Refill: ____________
Anticipated duration: ☐ 12 weeks ☐ 24 weeks ☐ Other ________

☐ **VIEKIRA XR**
Take 3 tablets a day, once daily, with a meal
Quantity: 84 Refill:
Anticipated duration: ☐ 12 weeks ☐ 24 weeks ☐ Other ________

☐ **EPLUSA** (Sofosbuvir/Velpatasvir) 400mg/100mg
Take 1 tablet daily
Quantity: 28 Refill:
Anticipated duration: ☐ 12 weeks ☐ 24 weeks ☐ Other

Ribavirin 200MG Quantity: Sig: Refill: ________

☐ **SOVALDI** (sofosbuvir) 400 mg tablet QD
Quantity: 28 Refill:
Anticipated duration: ☐ 12 weeks ☐ 24 weeks ☐ Other ________

☐ **DAKLINZA** (daclatasvir)
☐ 60 mg tablet QD Quantity: 28 Refill: ____________
☐ 30 mg tablet QD Quantity: 28 Refill: ____________
Anticipated duration: ☐ 12 weeks ☐ 24 weeks ☐ Other

☐ **TECHNIVIE** (ombitasvir, paritaprevir, and ritonavir)
Take 2 tablets in the morning with food.
Quantity: 56 Refill:
Anticipated duration: ☐ 12 weeks ☐ Other

☐ **ZEPATIER** (elbasvir and grazoprevir)
Quantity: 28 Refill: Take one tablet by mouth QD
Anticipated duration: ☐ 12 weeks ☐ 16 weeks ☐ Other

☐ **OLYSIO** (simeprevir) 150 mg QD
Quantity: 28 Refill:
Anticipated duration: ☐ 12 weeks ☐ 24 weeks ☐ Other

PRESCRIBER INFORMATION

# of Prescriptions: ______

Physician's Name (Please Print):
Address:
City, State, Zip:
Phone: Fax:
Physician's Signature:

NPI #:
License #:
DEA #:
Contact Name:
Date:

I authorize Metier Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

IMPORTANT NOTICE- This message is intended for use of only the name addressee and may contain information that is proprietary and confidential. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to named addressee.
-This prescription form is valid only if faxed directly by the prescriber or his/her authorized representative. Original prescription drug orders can only be accepted directly from the patients.
-The prescriber attests that he/she has advised the patient with the option of choosing a pharmacy of his/her choice.