SUPERIOR SPECIALTY PHARMACY
Transforming lives one patient at a time

HEPATITIS C ENROLLMENT
Patient Information

Phone: 813-960-2020
Fax: 813-549-3810
Toll Free: 877-436-2020

Patient Information

Patient: ______________________________
SS#: ______________ DOB: ______________ ☐ Male ☐ Female
Patient First Name: ______________ Patient Last Name: ______________ Caregiver: ______________
Address: ______________ City: ______________ State: ______ Zip: ______
Best Phone #: ______________ ☐ Cell Alternate Phone #: ______________ ☐ Cell
Email: ______________ Weight: ______ kgs or lbs (circle one) Recorded Date: ______________
Allergies: ______________ Comorbidities: ______________

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

Medical Assessment

Complete Entire Section or Fax Lab Report including Genotype/Subtype

Diagnosis: ☐ 070.54 HCV (Chronic) Genotype: ______ Subtype: ______
Previously treated for HCV? ☐ No ☐ Yes # of weeks: ______________
☐ Relapsed ☐ Partial Response ☐ Null Response
Liver biopsy done? ☐ No ☐ Yes Date: ______ Result: ______________

Lab	Result	Date
Hgb		
ALT		
AST		
HCV RNA		

Interferon

PEG-INTRON ☐ **REDIPEN** ☐ **VIAL**

Weight kg (lb)	Dosing (based on 1.5 mcg/kg/wk with Ribavirin)
<40 (<88)	☐ 50mcg (0.5mL) Sub-Q weekly
40-50 (88-111)	☐ 64mcg (0.4mL) Sub-Q weekly
51-60 (122-133)	☐ 80mcg (0.5mL) Sub-Q weekly
61-75 (134-166)	☐ 96mcg (0.4mL) Sub-Q weekly
76-85 (134-187)	☐ 120mcg (0.5mL) Sub-Q weekly
>85 (>187)	☐ 150mcg (0.5mL) Sub-Q weekly
Qty: 4 doses (28 days)	Refill #: ______________

Ribavirin

RIBASPHERE (RIBAVIRIN GEQ) 200mg
☐ **Tablet** or ☐ **Capsule**

Dose	Qty	Refill
☐ 400 mg q AM and 200 mg q PM	Qty: 84	Refill: ______________
☐ 400 mg q AM and 400 mg q PM	Qty: 112	Refill: ______________
☐ 600 mg q AM and 400 mg q PM	Qty: 140	Refill: ______________
☐ 600 mg q AM and 600 mg q PM	Qty: 168	Refill: ______________
☐ 600 mg q AM and 800 mg q PM	Qty: 196	Refill: ______________

Protease Inhibitor

SOVALDI (Sofosbuvir) 400mg
☐ 400mg (1 tablet) once daily
Quantity: 28 tablets (28 days) Refill #: ________

OLYSIO (Simeprevir) 150mg
☐ 150mg (1 capsule) once daily with food (not low fat) for 12 weeks
Quantity: 28 tablets (28 days) Refill #: 2

VIEKIRA PAK
☐ Take 2 tablets (ombitasvir/paritaprevir/ritonavir) once daily in the morning and 1 tablet (dasabuvir) twice daily in the morning and evening with a meal as directed by the Pak
Quantity: 28 days Refill #: ________

Polymerase Inhibitor

HARVONI (Ledipasvir/Sofosbuvir)
☐ 90mg/400mg (1 tablet) once daily
Quantity: 28 tablets (28 days)
Refill #: ________

Supportive Therapies

Superior Specialty can provide supportive therapy, such as:

- Procrit
- Neupogen
- Epogen
- Neulasta
- Aranesp
- Promacta

Please provide an attached Rx if supportive therapy is needed.

INJECTION TRAINING

☐ Superior Specialty will coordinate training ☐ Physician Office to coordinate training
RN/LPN to teach administration of injectable to caregiver/patient (in accordance with state laws)

LAB COORDINATION

☐ Superior Specialty to Coordinate (please fill out lab request form)

Prescriber Information

Anticipated Start Date: ______________ Physician Specialty: ______________ Ship to: ☐ Patient ☐ Physician/Clinic
☐ Other: ______________________________
Physician: ______________________________

Phone #: ______________ Fax #: ______________ NPI #: ______ Contact Name: ______________
Office Address: ______________ City: ______________ State: ______ Zip: ______
I authorize Superior Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process, coordinate and receive lab values, and arrange injection training.
Physician's Signature: ______________________________ Date: ______________