



Hepatitis C Enrollment Form

Phone: 855-425-4085

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ardonhealth.com

PATIENT INFORMATION	Patient Name: _____	PRESCRIBER INFORMATION	Prescriber's Name: _____
	Address: _____		State License #: _____ NPI #: _____
	City: _____ State: _____ Zip: _____		DEA #: _____
	Primary Phone: _____ DOB: _____		Group or Hospital: _____
	Alternate Phone: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Address: _____
	Email: _____		City: _____ State: _____ Zip: _____
	Last Four of SS #: _____ Primary Language: _____		Phone: _____ Fax: _____
	Height: _____ Weight: _____		Contact Person: _____ Phone: _____

INSURANCE INFORMATION: PLEASE FAX A COPY OF THE PRESCRIPTION & INSURANCE CARDS WITH THIS FORM, IF AVAILABLE (FRONT & BACK)

CLINICAL	Need By Date: _____	Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Physician <input type="checkbox"/> Other:		
	Date of Diagnosis: _____	Diagnosis ICD-10 Code: Chronic Viral Hepatitis C B18.2 <input type="checkbox"/>	Viral Load: _____	Date: _____
	Previous Failed Medications for HCV: _____			
	Current Medications: _____			
	Allergies: _____	HCV Therapy Treatment Duration: _____ weeks		
	Previously treated for HCV? <input type="checkbox"/> Yes <input type="checkbox"/> No	Fibrosis: <input type="checkbox"/> F0 <input type="checkbox"/> F1 <input type="checkbox"/> F2 <input type="checkbox"/> F3 <input type="checkbox"/> F4		
Genotype <input type="checkbox"/> 1a <input type="checkbox"/> 1b <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6		Child-Pugh Score: _____		

	MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILL
PRESCRIPTION INFORMATION	<input type="checkbox"/> Epclusa	<input type="checkbox"/> 400/100mg Tab	<input type="checkbox"/> Take 1 Tab PO Daily	<input type="checkbox"/> 28	
	<input type="checkbox"/> Harvoni	<input type="checkbox"/> 400/90mg Tab	<input type="checkbox"/> Take 1 Tab PO Daily	<input type="checkbox"/> 28	
	<input type="checkbox"/> Sovaldi	<input type="checkbox"/> 400mg Tab	<input type="checkbox"/> Take 1 Tab PO Daily	<input type="checkbox"/> 28	
	<input type="checkbox"/> Ribavirin	<input type="checkbox"/> 200mg Tab <input type="checkbox"/> 200mg Cap	<input type="checkbox"/> Take _____mg PO Every Morning and _____mg PO Every Evening	_____	
	<input type="checkbox"/> Viekira	<input type="checkbox"/> Viekira Pak <input type="checkbox"/> Viekira XR Pak	<input type="checkbox"/> Take 2 Pink Tablets PO Once Daily and 1 Beige Tablet Twice Daily with Food <input type="checkbox"/> Take 3 XR Tablets PO Once Daily	<input type="checkbox"/> 1 Viekira Pak (112 tabs) <input type="checkbox"/> 1 Viekira XR Pak (84 tabs)	
	<input type="checkbox"/> Technivie	<input type="checkbox"/> 12.5/75/50mg	<input type="checkbox"/> Take 2 Tabs PO Daily	<input type="checkbox"/> 56	
	<input type="checkbox"/> Daklinza	<input type="checkbox"/> 30mg Tab <input type="checkbox"/> 60mg Tab <input type="checkbox"/> 90mg Tab	<input type="checkbox"/> Take 1 Tab PO Daily	<input type="checkbox"/> 28	
	<input type="checkbox"/> Zepatier	<input type="checkbox"/> 50-100mg Tab	<input type="checkbox"/> Take 1 Tab PO Daily Has NS5A resistance testing been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 28	
	<input type="checkbox"/> Olysio	<input type="checkbox"/> 150mg Cap	<input type="checkbox"/> Take 1 Cap PO Daily	<input type="checkbox"/> 28	
	<input type="checkbox"/> Other			<input type="checkbox"/>	

X _____ **PRODUCT SUBSTITUTION PERMITTED** (Date) _____
 Ancillary supplies and kits will be provided as needed for administration.

X _____ **DISPENSE AS WRITTEN** (Date) _____

Date Needed: _____ Medication Start Date: _____

The information included in this FAX is intended for the sole use of the individual to whom it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If you are not the intended addressee, nor authorized to receive for the intended addressee, you are hereby notified that you may not use, copy, disclose or distribute this information. If you have received this FAX in error, please contact the sender and destroy the entire document. 15561868 (11/16)