ardon

Hepatitis C Enrollment Form
Phone: 855-425-4085
Fax: 855-425-4096
ardonhealth.com

PATIENT INFORMATION

Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Primary Phone: _____ DOB: _____
Alternate Phone: _____ Gender: ☐ Male ☐ Female
Email: _____
Last Four of SS #: _____ Primary Language: _____
Height: _____ Weight: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ NPI #: _____
DEA #: _____
Group or Hospital: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
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**: ☐ Patient ☐ Physician ☐ Other:
Date of Diagnosis:	**Diagnosis ICD-10 Code: Chronic Viral Hepatitis C B18.2** ☐ **Viral Load:** **Date:**
Previous Failed Medications for HCV:	
Current Medications:	
Allergies:	**HCV Therapy Treatment Duration:** _____weeks
Previously treated for HCV? ☐ Yes ☐ No	**Fibrosis:** ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4
Genotype ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6	**Child-Pugh Score:**

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILL
☐ **Epclusa**	☐ 400/100mg Tab	☐ Take 1 Tab PO Daily	☐ 28	☐
☐ **Vosevi**	☐ 400/100/100mg Tab	☐ Take 1 Tab PO Daily with food	☐ 28	☐
☐ **Mavyret**	☐ 100/40mg Tab	☐ Take 3 Tabs PO Daily with food	☐ 84	☐
☐ **Harvoni**	☐ 400/90mg Tab	☐ Take 1 Tab PO Daily	☐ 28	☐
☐ **Sovaldi**	☐ 400mg Tab	☐ Take 1 Tab PO Daily	☐ 28	☐
☐ **Ribavirin**	☐ 200mg Tab ☐ 200mg Cap	☐ Take ____mg PO Every Morning and ____mg PO Every Evening	____	☐
☐ **Viekira**	☐ Viekira Pak ☐ Viekira XR Pak	☐ Take 2 Pink Tablets PO Once Daily and 1 Beige Tablet Twice Daily with Food ☐ Take 3 XR Tablets PO Once Daily	☐ 1 Viekira Pak (112 tabs) ☐ 1 Viekira XR Pak (84 tabs)	☐
☐ **Technivie**	☐ 12.5/75/50mg	☐ Take 2 Tabs PO Daily	☐ 56	☐
☐ **Daklinza**	☐ 30mg Tab ☐ 60mg Tab ☐ 90mg Tab	☐ Take 1 Tab PO Daily	☐ 28	☐
☐ **Zepatier**	☐ 50-100mg Tab	☐ Take 1 Tab PO Daily Has NS5A resistance testing been completed? ☐Yes ☐ No	☐ 28	☐
☐ **Olysio**	☐ 150mg Cap	☐ Take 1 Cap PO Daily	☐ 28	☐
☐ **Other**			☐	☐

X _____ **X** _____

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

Ancillary supplies and kits will be provided as needed for administration.

PHYSICIAN SIGNATURE REQUIRED

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)