Hepatitis C
enrollment form

Phone: 855-425-4085 **Fax:** 855-425-4096 **ardonhealth.com**

ardon

Date needed	Medication start date	Ship to: ☐Patient ☐Physician ☐Other:

Patient information

Patient name	Date of birth		Phone	Alternate phone	
Address		City	State	ZIP	
Gender: ☐Male ☐Female	Email	Primary language		Height	Weight

Prescriber information

Prescriber name	State License #	NPI #	DEA #	
Group or hospital	Address	City	State	ZIP
Phone	Fax	Contact person name and phone		

Insurance information: If available, please fax a copy of the prescription and insurance card(s) with this form (front and back).

Clinical

Date of diagnosis	Diagnosis ICD-10 code: ☐Chronic Viral Hepatitis C B18.2 ☐Acute Hepatitis C Without Hepatic Coma B17.10 ☐Acute hepatitis C With Hepatic Coma B17.11 Viral load: _____ Date: _____
Previous medications for HCV:	Current medications:
Allergies:	HCV therapy treatment duration: _____ weeks
Previously treated for this HCV infection? ☐Yes (treatment-experienced) ☐No (treatment-naïve)	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 ☐Sofosbuvir/ Velpatasvir	☐400/100 mg Tablet	☐Take 1 tablet by mouth once daily	☐28 Tablets	
☐Epclusa (Pediatric)	☐200/50 mg Tablet ☐200/50 mg Packet	☐Take _____ tablet(s)/packet(s) by mouth once daily	_____ Tablets/ Packets	
	☐150/37.5 mg Packet	☐Take 1 packet by mouth once daily	☐28 Packets	
☐Harvoni ☐Ledipasvir/ Sofosbuvir	☐90/400 mg Tablet	☐Take 1 tablet by mouth once daily	☐28 Tablets	
☐Harvoni (Pediatric)	☐45/200 mg Tablet ☐45/200 mg Packet	☐Take _____ tablet(s)/packet(s) by mouth once daily	_____ Tablets/ Packets	
	☐33.75/150 mg Packet	☐Take 1 packet by mouth once daily	☐28 Packets	

Physician signature required

Product substitution permitted	**Dispense as written**
X _____ Date _____	X _____ Date _____

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

This prescription is valid only if transmitted by facsimile machine by a licensed provider.

☐ Mavyret	☐ 100/40 mg Tablet	☐ Take 3 tablets by mouth once daily with food	☐ 84 Tablets	
☐ Mavyret (Pediatric)	☐ 50/20 mg Packet	☐ Take _____ packets by mouth once daily with food	_____ Packets	
☐ Ribavirin	☐ 200 mg Tablet ☐ 200 mg Capsule	☐ Take _____ tablet(s)/capsule(s) by mouth every morning and _____ tablet(s)/capsule(s) every evening	_____ Tablets/ Capsules	
☐ Sovaldi	☐ 400 mg Tablet	☐ Take 1 tablet by mouth once daily	☐ 28 Tablets	
☐ Sovaldi (Pediatric)	☐ 200 mg Tablet ☐ 200 mg Packet	☐ Take _____ tablet(s)/packet(s) by mouth once daily	☐ 28 Tablets/ Packets	
	☐ 150 mg Packet	☐ Take 1 packet by mouth once daily	☐ 28 Packets	
☐ Vosevi	☐ 400/100/100 mg Tablet	☐ Take 1 tablet by mouth once daily with food	☐ 28 Tablets	
☐ Zepatier	☐ 50/100 mg Tablet	☐ Take 1 tablet by mouth once daily *If GT 1a, has NS5A resistance testing been completed?* ☐ Yes ☐ No *If yes, does the patient have baseline NS5A polymorphisms?* ☐ Yes ☐ No	☐ 28 Tablets	
☐ Other				

Physician signature required

Product substitution permitted	**Dispense as written**
X _____ Date _____	X _____ Date _____

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