



SPECIALTY PHARMACY

## HEPATOLOGY

Orlando, FL toll free 855.274.1694 toll free fax 855.819.6922

krogerspecialtypharmacy.com

DATE: \_\_\_\_\_ NEEDS BY DATE: \_\_\_\_\_ SHIP TO: ☐ PATIENT ☐ OFFICE ☐ OTHER \_\_\_\_\_

PATIENT INFO		PRESCRIBER INFO	
Patient Name		Prescriber Name	
Address		DEA #	NPI # License #
City, State, Zip		Address	
Main Phone	Alternate Phone	City, State, Zip	
Social Security #		Phone	Fax
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Contact Person	

PLEASE FAX COPY OF: ☐ PRESCRIPTION CARD FRONT & BACK ☐ CLINICAL NOTES ☐ MEDICAL CARD FRONT & BACK

## CLINICAL INFORMATION

☐ B18.2 Chronic Hepatitis C ☐ K72.90 ☐ K72.91 Hepatic Encephalopathy ☐ C22.0 ☐ C22.2 ☐ C22.7 ☐ C22.8 Hepatocellular Carcinoma☐ Other: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Genotype: ☐ 1 ☐ 1a (NS5A RAVs: \_\_\_\_ Yes \_\_\_\_ No) ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 Viral Load: \_\_\_\_\_ IU/ml Viral Load Date : \_\_\_\_\_☐ Treatment Naive ☐ Previously Treated: Prior treatment used: \_\_\_\_\_ ☐ Non-Responder ☐ Responder/RelapserDuration of previous therapy: From \_\_\_\_\_ to \_\_\_\_\_ Total of: \_\_\_\_\_ months HIV Coinfected: ☐ Yes ☐ No HBV Coinfected: ☐ Yes ☐ NoCompensated Liver Disease: ☐ Yes ☐ No Cirrhosis: ☐ Yes ☐ No Metavir Score: \_\_\_\_\_ Solid Organ Transplant recipient: ☐ Yes ☐ No Awaiting Liver Transplant?: ☐ Yes ☐ No

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
<input type="checkbox"/> Daklinza™	<input type="checkbox"/> 60mg <input type="checkbox"/> 30mg <input type="checkbox"/> 90mg	Take 1 tablet by mouth daily with or without food in combination with Sovaldi®	28 day supply	_____
<input type="checkbox"/> Epclusa®	sofosbuvir and velpatasvir 400mg/100mg	Take 1 tablet by mouth daily with or without food	28 day supply	_____
<input type="checkbox"/> Harvoni®	ledipasvir and sofosbuvir 90mg/400mg	Take 1 tablet by mouth daily with or without food	28 day supply	_____
<input type="checkbox"/> Mavyret®	glecaprevir/pibrentasvir 100mg/40mg	Take 3 tablets by mouth daily with food	28 day supply	_____
<input type="checkbox"/> Olysio®	150mg	Take 1 capsule by mouth daily with food	28 day supply	_____
<input type="checkbox"/> Sovaldi®	400mg	Take 1 tablet by mouth daily with or without food	28 day supply	_____
<input type="checkbox"/> Technivie™	ombitasvir, paritaprevir, ritonavir (12.5/75/50mg)	Take 2 tablets by mouth daily with food in the morning	28 day supply	_____
<input type="checkbox"/> Viekira Pak®	ombitasvir, paritaprevir, ritonavir (12.5/75/50mg) dasabuvir 250mg	Take 2 tablets (pink) once daily in the morning and 1 tablet (beige) twice daily in the morning and evening with a meal	28 day supply	_____
<input type="checkbox"/> Viekira XR™	ombitasvir, paritaprevir, ritonavir, dasabuvir (8.33/50/33.3/200mg)	Take 3 tablets by mouth once daily with food	28 day supply	_____
<input type="checkbox"/> Vosevi™	sofosbuvir, velpatasvir, voxilaprevir (400/100/100mg)	Take 1 tablet by mouth daily with food	28 day supply	_____
<input type="checkbox"/> Zepatier™	elbasvir/grazoprevir (50mg/100mg)	Take 1 tablet by mouth daily with or without food	28 day supply	_____
<input type="checkbox"/> Moderiba	200mg Tablet	<input type="checkbox"/> 600mg AM and 600mg PM (1200mg) <input type="checkbox"/> 600mg AM and 400mg PM (1000mg)	28 day supply	_____
<input type="checkbox"/> Ribavirin	200mg <input type="checkbox"/> Tabs <input type="checkbox"/> Caps	<input type="checkbox"/> 400mg AM and 400mg PM (800mg) <input type="checkbox"/> 400mg AM and 200mg PM (600mg)		
<input type="checkbox"/> Ribasphere®	200mg <input type="checkbox"/> Tabs <input type="checkbox"/> Caps	<input type="checkbox"/> Other: Take _____ mg AM and _____ mg PM		
<input type="checkbox"/> Riba-Pak®		<input type="checkbox"/> 600mg AM and 600mg PM (1200mg) <input type="checkbox"/> 600mg AM and 400mg PM (1000mg)		_____
<input type="checkbox"/> Moderiba Pak®		<input type="checkbox"/> 400mg AM and 400mg PM (800mg) <input type="checkbox"/> 400mg AM and 200mg PM (600mg)	28 day supply	_____
<input type="checkbox"/> Xifaxan	550mg Tablet	Take 1 tablet by mouth twice daily **indicate previously failed therapy (Lactulose) _____	30 day supply	_____
<input type="checkbox"/> Other				_____

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Substitution Permitted Date Prescriber's Signature (no stamps) Dispense As Written Date

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