DELTADRUGS

Hepatitis C

437 Fernando Court • Glendale, CA 91204 • **MAIN:** 818.309.2884 • **FAX:** 818.309.1704 • www.deltadrugs.com

RESET FORM

PATIENT INFORMATION

Patient Name: _____

Address: _____

City, State, Zip: _____

Phone #: _____ Secondary Phone #: _____

Patient SSN#: _____ Date of Birth: _____

Weight (lbs): _____ Height (in.): _____ Gender: ❑ Male ❑ Female

Allergies: _____

Primary Insurance: _____

ID#: _____ Phone #: _____

Secondary Insurance: _____

ID#: _____ Phone #: _____

FAX COPY OF INSURANCE CARD (FRONT & BACK)

PHYSICIAN INFORMATION

Physician Name: _____

Contact: _____

NPI #: _____

Address: _____

_____
City, State, Zip Code

Phone #: _____

Alt Phone #: _____

Fax #: _____

Email: _____

Ship Rx to: ❑ Physician's Office ❑ Patient's home

CLINICAL INFORMATION

ICD-10 Diagnosis
❑ B18.2 Chronic Hepatitis C Virus

Genotype: ❑ 1a ❑ 1b ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6

Treatment type: ❑ naïve ❑ Interferon-experienced ❑ DAA-experienced

Baseline viral load: _____ Date: _____

Degree of fibrosis: ❑ F0 ❑ F1 ❑ F3 ❑ F4 Other fibrosis score: _____

Cirrhosis: ❑ Compensated ❑ Decompensated ❑ None

Child-Pugh class: ❑ A ❑ B ❑ C

Co-infection(s): ❑ HBV ❑ HIV ❑ None

Transplant status: ❑ Pre-transplant ❑ Post-Transplant ❑ N/A

CKD stage: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ N/A Dialysis: ❑ Yes ❑ No

IL28B: ❑ CC ❑ CT ❑ TT NS5A polymorphism: ❑ Yes ❑ No

NS5A polymorphism type: ❑ M28 ❑ Q30 ❑ L31 ❑ Y93 ❑ _____

Comorbidities: _____

Medication Reconciliation: _____

Prior Treatment/Therapy (If Any)	Reason for Discontinuation	Start and End Date of Therapy

FAX COPY OF ALL RELATED CLINICAL/LAB INFO

MEDICATION	DIRECTIONS	DURATION	QTY	REFILLS
❑ DAKLINZA®	❑ Take 60 mg by mouth once daily	❑ 12 weeks ❑ 24 weeks	❑ 28 tablets	
	❑ Take 30 mg by mouth once daily		❑ 28 tablets ❑ _____	
❑ HARVONI®	❑ Take 90 mg/400 mg by mouth once daily	❑ 8 wks ❑ 12 wks ❑ 24 wks	❑ 28 tablets	
❑ OLYSIO®	❑ Take 150 mg by mouth once daily	❑ 12 weeks ❑ 24 weeks	❑ 28 capsules	
❑ SOVALDI®	❑ Take 400 mg by mouth once daily	❑ 12 weeks ❑ 24 weeks	❑ 28 tablets	
❑ TECHNIVIE™	❑ Take 2 tablets in the morning by mouth w/food	❑ 12 weeks	❑ 56 tablets	
❑ VIEKIRA PAK™	❑ 3 tablets in morning / 1 tablet in evening by mouth w/food	❑ 12 weeks ❑ 24 weeks	❑ 112 tablets	
❑ ZEPATIER™	❑ Take 50 mg/100 mg by mouth once daily	❑ 12 weeks ❑ 16 weeks	❑ 28 tablets	
❑ PEGASYS PFS	❑ 180 mcg SQ every week		❑ 4 PFS ❑ _____	
❑ PEGASYS PROCLICK	❑ 180 mcg/0.5 mL SQ every week		❑ 4 Autoinjector	
❑ RIBASPHERE® RIBAPAK® ❑ MODERIBA™	❑ 600 mg tablet QAM / 400 mg tablet QPM ❑ 600 mg tablet QAM / 600 mg tablet QPM ❑ 200 mg QAM / 400 mg tablet QPM ❑ 400 mg tablet QAM / 400 mg tablet QPM		❑ 56 tablets	
❑ RIBASPHERE® ❑ RIBAVIRIN *200 mg*	❑ Take 1 tabs/caps QAM | 2 tabs/caps QPM (84) ❑ Take 2 tabs/caps QAM | 2 tabs/caps QPM (112) ❑ Take 3 tabs/caps QAM | 2 tabs/caps QPM (140) ❑ Take 3 tabs/caps QAM | 3 tabs/caps QPM (168) ❑ Take 4 tabs/caps QAM | 3 tabs/caps QPM (196) ❑ Tablets ❑ Capsules			

Physician's Signature: _____ Date: _____ ❑ Dispense As Written

I AUTHORIZE DELTA DRUGS AND ITS REPRESENTATIVES TO ACT AS AN AGENT TO INITIATE AND EXECUTE THE INSURANCE PRIOR AUTHORIZATION PROCESS.