

PATIENT INFORMATION **ENROLLMENT CHECKLIST**

<p>Written Date: _____</p> <p>Ship To:</p> <p><input type="checkbox"/> Pick up 1st fill at Dolphin Health</p> <p><input type="checkbox"/> Provider (1st Fill Only)</p> <p><input type="checkbox"/> Provider (All Fills)</p> <p>Permission to Contact Patient:</p> <p><input type="checkbox"/> Yes, OK to call patient</p> <p><input type="checkbox"/> No, not OK to call patient</p>	<p>Patient Name: _____</p> <p>Date of Birth: _____</p> <p>SSN: _____</p> <p>Address: _____</p> <p>City, State, Zip Code: _____</p> <p>Phone: _____</p> <p>Email Address: _____</p> <p>Preferred language: _____</p> <p>Contact Person: _____</p>	<p align="center">PLEASE PROVIDE FOR ALL PATIENTS</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Demographics</td> <td><input type="checkbox"/> Fibrosis documentation (Biopsy, Fibroscan, Fibrosure)</td> </tr> <tr> <td><input type="checkbox"/> Insurance cards</td> <td><input type="checkbox"/> Imaging (*if available)</td> </tr> <tr> <td><input type="checkbox"/> Last 2 visit notes</td> <td><input type="checkbox"/> PT/INR (*if cirrhotic)</td> </tr> <tr> <td><input type="checkbox"/> HCV Genotype</td> <td><input type="checkbox"/> NS3A Resistance Testing</td> </tr> <tr> <td><input type="checkbox"/> HCV RNA (Last 90 days)</td> <td><input type="checkbox"/> Current Med List</td> </tr> <tr> <td><input type="checkbox"/> CBC w/ PLT (Last 90 days)</td> <td><input type="checkbox"/> Pt adherence/readiness documentation</td> </tr> <tr> <td><input type="checkbox"/> NS5A Resistance Testing for GT1a</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Complete Metabolic Panel (Last 90 days)</td> <td></td> </tr> </table>	<input type="checkbox"/> Demographics	<input type="checkbox"/> Fibrosis documentation (Biopsy, Fibroscan, Fibrosure)	<input type="checkbox"/> Insurance cards	<input type="checkbox"/> Imaging (*if available)	<input type="checkbox"/> Last 2 visit notes	<input type="checkbox"/> PT/INR (*if cirrhotic)	<input type="checkbox"/> HCV Genotype	<input type="checkbox"/> NS3A Resistance Testing	<input type="checkbox"/> HCV RNA (Last 90 days)	<input type="checkbox"/> Current Med List	<input type="checkbox"/> CBC w/ PLT (Last 90 days)	<input type="checkbox"/> Pt adherence/readiness documentation	<input type="checkbox"/> NS5A Resistance Testing for GT1a		<input type="checkbox"/> Complete Metabolic Panel (Last 90 days)	
<input type="checkbox"/> Demographics	<input type="checkbox"/> Fibrosis documentation (Biopsy, Fibroscan, Fibrosure)																	
<input type="checkbox"/> Insurance cards	<input type="checkbox"/> Imaging (*if available)																	
<input type="checkbox"/> Last 2 visit notes	<input type="checkbox"/> PT/INR (*if cirrhotic)																	
<input type="checkbox"/> HCV Genotype	<input type="checkbox"/> NS3A Resistance Testing																	
<input type="checkbox"/> HCV RNA (Last 90 days)	<input type="checkbox"/> Current Med List																	
<input type="checkbox"/> CBC w/ PLT (Last 90 days)	<input type="checkbox"/> Pt adherence/readiness documentation																	
<input type="checkbox"/> NS5A Resistance Testing for GT1a																		
<input type="checkbox"/> Complete Metabolic Panel (Last 90 days)																		

DIAGNOSIS INFORMATION (Please include supporting documents) **HIGH PRIORITY FOR TREATMENT**

<p>Diagnosis:</p> <p><input type="checkbox"/> B18.2 Hepatitis C</p> <p><input type="checkbox"/> HCV/HIV Co-infection</p> <p><input type="checkbox"/> HCV/HBV Co-infection</p> <p><input type="checkbox"/> HCC</p> <p><input type="checkbox"/> Pre/post- transplant</p> <p>Height: _____</p> <p>Weight: _____</p>	<p>Genotype:</p> <p><input type="checkbox"/> 1A <input type="checkbox"/> 4</p> <p><input type="checkbox"/> 1B <input type="checkbox"/> 5</p> <p><input type="checkbox"/> 2 <input type="checkbox"/> 6</p> <p><input type="checkbox"/> 3</p> <p><input type="checkbox"/> Other: _____</p> <p>Allergies: _____</p>	<p>Prior treatment history:</p> <p><input type="checkbox"/> Naive <input type="checkbox"/> Relapser <input type="checkbox"/> Non-Responder</p> <p><input type="checkbox"/> Discontinued due to side effects</p> <p>Prior treatment regimen:</p> <p><input type="checkbox"/> RBV <input type="checkbox"/> IFN <input type="checkbox"/> Harvoni <input type="checkbox"/> Sovaldi</p> <p><input type="checkbox"/> Olysio <input type="checkbox"/> Incivek <input type="checkbox"/> Victrelis <input type="checkbox"/> Other: _____</p> <p>Stage of Fibrosis</p> <p><input type="checkbox"/> F0 <input type="checkbox"/> F1 <input type="checkbox"/> F2 <input type="checkbox"/> F3 <input type="checkbox"/> F4 APRI score: _____</p>
---	--	--

CURRENT TREATMENT REGIMENS

Genotype	Available Regimens	Duration	Notes
Genotype 1	Zepatier	12 weeks	Tx naïve or PegIFN/RBV-experienced without baseline NS5A polymorphisms (GT1a) or Tx naïve or PegIFN/RBV-experienced (GT1b) or CrCl < 30 mL/min (GT1a or GT1b)
	Epclusa	12 weeks	Tx naïve or PegIFN/RBV-experienced GT1a with baseline NS5A polymorphisms or GT1a/GT1b decompensated cirrhosis (Child-Pugh B & C)
Genotype 2	Epclusa	12 weeks	Non-cirrhotic & compensated cirrhosis (Child-Pugh A)
	Epclusa + RBV	12 weeks	Decompensated cirrhosis (Child-Pugh B & C) or Sovaldi/RBV-experienced
Genotype 3	Epclusa	12 weeks	Non-cirrhotic & compensated cirrhosis (Child-Pugh A)
	Epclusa + RBV	12 weeks	Decompensated cirrhosis (Child-Pugh B & C) or Sovaldi/RBV-experienced or PegIFN/RBV-experienced with cirrhosis
Genotype 4	Epclusa	12 weeks	Non-cirrhotic & compensated cirrhosis (Child-Pugh A)
	Epclusa + RBV	12 weeks	Decompensated cirrhosis (Child-Pugh B & C)
	Zepatier	12 weeks	CrCl < 30 mL/min
Genotype 5 & 6	Epclusa	12 weeks	Non-cirrhotic & compensated cirrhosis (Child-Pugh A)
	Epclusa + RBV	12 weeks	Decompensated cirrhosis (Child-Pugh B & C)

(Please select all that apply)

Please include labs and/or notes

COMORBIDITIES

HIV co-infection

HBV co-infection

Type 2 DM

Debilitating fatigue due to HCV infection

EXTRAHEPATIC MANIFESTATIONS

Porphyria cutanea tarda

Symptomatic cryoglobulinemia

HCV-related kidney disease

ELEVATED RISK OF HCV TRANSMISSION

MSM w/ high risk sexual practices

Active IVDU

Long-term HD

Women of child-bearing potential wishing to get pregnant

HCV infected Healthcare worker who performs exposure prone procedures

TREATMENT REGIMEN & PRESCRIPTION

	MEDICATION	STRENGTH	DIRECTIONS	DISPENSE QTY	DURATION
NS5A INHIBITOR & NS3/4A PI	<input type="checkbox"/> ZEPATIER™	50/100mg	Take 1 tablet by mouth once daily	<input type="checkbox"/> Up to 30 days <input type="checkbox"/> Up to 90 days	
NS5A Inhibitor & NS5B PI	<input type="checkbox"/> EPCLUSA®	100/400mg	Take 1 tablet by mouth once daily	<input type="checkbox"/> Up to 30 days <input type="checkbox"/> Up to 90 days	
NS5A Inhibitor & NS5B PI	<input type="checkbox"/> HARVONI®	90/400mg	Take 1 tablet by mouth once daily	<input type="checkbox"/> Up to 30 days <input type="checkbox"/> Up to 90 days	
3D COMBINATION	<input type="checkbox"/> VIEKIRA XR™	25/150/100/600 mg	Take 3 tablets by mouth once daily with food	<input type="checkbox"/> Up to 30 days <input type="checkbox"/> Up to 90 days	
POLYMERASE INHIBITORS	<input type="checkbox"/> SOVALDI™	400mg	Take 1 tablet by mouth once daily	<input type="checkbox"/> Up to 30 days <input type="checkbox"/> Up to 90 days	
NS5A INHIBITOR	<input type="checkbox"/> DAKLINZA™	<input type="checkbox"/> 30mg <input type="checkbox"/> 60mg (normal dosage) <input type="checkbox"/> 90mg	Take one tablet by mouth once daily with sofosbuvir	<input type="checkbox"/> Up to 30 days <input type="checkbox"/> Up to 90 days	
COMBINATION	<input type="checkbox"/> TECHNIVIE™	12.5/75/50 mg	Take 2 tablets by mouth once daily with food	<input type="checkbox"/> Up to 30 days <input type="checkbox"/> Up to 90 days	
RIBAVIRIN	<input type="checkbox"/> RIBAPAK® <input type="checkbox"/> DAW1 (or ribavirin equivalent)	<input type="checkbox"/> 600mg <input type="checkbox"/> 800mg <input type="checkbox"/> 1000mg (≤75kg) <input type="checkbox"/> 1200mg (>75kg) <input type="checkbox"/> 1400mg	400mg QAM, 200mg QPM, with food 400mg QAM, 400mg QPM, with food 600mg QAM, 400mg QPM, with food 600mg QAM, 600mg QPM, with food 800mg QAM, 600mg QPM, with food	<input type="checkbox"/> Up to 30 days <input type="checkbox"/> Up to 90 days	
OTHER	<input type="checkbox"/> _____	<input type="checkbox"/> _____			

PROVIDER AUTHORIZATION & INFORMATION

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to Dolphin Health to act as the prescriber's agent to begin and To execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Name: _____ Address: _____

DEA: _____ NPI: _____ City, State, ZIP Code: _____

Phone: _____ Fax: _____ Contact Person: _____

Date: _____ Provider Signature: _____ Do not substitute