

PATIENT INFORMATION **ENROLLMENT CHECKLIST**

Written Date: _____ Ship To: <input type="checkbox"/> Patient (All Fills) <input type="checkbox"/> Provider (1st Fill Only) <input type="checkbox"/> Provider (All Fills) <input type="checkbox"/> Other: _____	Patient Name: _____ Date of Birth: _____ SSN: _____ Address: _____ City, State, Zip Code: _____ Phone: _____ Email Address: _____ Preferred language: _____ Contact Person: _____	<p style="text-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"/> NS5A and/or 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"/> 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"/> NS5A and/or 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"/> Complete Metabolic Panel (Last 90 days)	
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DIAGNOSIS INFORMATION (Please include supporting documents) **HIGH PRIORITY FOR TREATMENT**

Diagnosis: <input type="checkbox"/> B18.2 Hepatitis C <input type="checkbox"/> HCV/HIV Co-infection <input type="checkbox"/> HCV/HBV Co-infection <input type="checkbox"/> HCC <input type="checkbox"/> Pre/post- transplant Height: _____ Weight: _____	Genotype: <input type="checkbox"/> 1A <input type="checkbox"/> 4 <input type="checkbox"/> 1B <input type="checkbox"/> 5 <input type="checkbox"/> 2 <input type="checkbox"/> 6 <input type="checkbox"/> 3 <input type="checkbox"/> Other: _____ Allergies: _____	Prior treatment history: <input type="checkbox"/> Naive <input type="checkbox"/> Relapser <input type="checkbox"/> Non-Responder <input type="checkbox"/> Discontinued due to side effects Prior treatment regimen: <input type="checkbox"/> RBV <input type="checkbox"/> IFN <input type="checkbox"/> Harvoni <input type="checkbox"/> Sovaldi <input type="checkbox"/> Olysio <input type="checkbox"/> Incivek <input type="checkbox"/> Victrelis <input type="checkbox"/> Other: _____ Stage of Fibrosis <input type="checkbox"/> F0 <input type="checkbox"/> F1 <input type="checkbox"/> F2 <input type="checkbox"/> F3 <input type="checkbox"/> F4 APRI score: _____	<p style="text-align: center;">(Please select all that apply) Please include labs and/or notes</p> <p>COMORBIDITIES</p> <input type="checkbox"/> HIV co-infection <input type="checkbox"/> HBV co-infection <input type="checkbox"/> Type 2 DM <input type="checkbox"/> Debilitating fatigue <p>EXTRAHEPATIC MANIFESTATIONS</p> <input type="checkbox"/> Porphyria cutanea tarda <input type="checkbox"/> Symptomatic cryoglobulinemia <input type="checkbox"/> HCV-related kidney disease <p>ELEVATED RISK OF HCV TRANSMISSION</p> <input type="checkbox"/> MSM w/ high risk sexual practices <input type="checkbox"/> Active IVDU <input type="checkbox"/> Long-term HD <input type="checkbox"/> Women of child-bearing potential wishing to get pregnant <input type="checkbox"/> HCV infected Healthcare worker who performs exposure prone procedures
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CURRENT TREATMENT REGIMENS

Genotype	Available Regimens	Duration	Notes	
Genotype 1	Epclusa Epclusa + RBV Harvoni	12 weeks 12 weeks 8 weeks	Non-cirrhotic & compensated cirrhosis (Child-Pugh A) Decompensated cirrhosis (Child-Pugh B & C) 8 wks = Tx naive, w/o cirrhosis, baseline VL < 6 million 12 wks = Tx naive w/cirrhosis & tx experienced w/o cirrhosis 24 wks = Tx experienced w/ cirrhosis GT 1b w/o cirrhosis Tx naive or IFN/RBV-experienced without baseline NS5A polymorphisms (GT1a) or Tx naive or IFN/RBV-experienced (GT1b) GT1a or GT1b, IFN/RBV/PI-experienced GT1a, tx naive or IFN/RBV-experienced with baseline NS5A polymorphisms GT1b w/ or w/o compensated cirrhosis GT1a w/o cirrhosis GT1a w/ compensated cirrhosis	
	Zepatier	12 weeks		
	Zepatier + RBV Zepatier + RBV	12 weeks 16 weeks		
	Viekira XR Viekira XR + RBV	12 weeks 24 weeks		
	Viekira XR + RBV	24 weeks		
Genotype 2	Epclusa Epclusa + RBV Sovaldi + RBV	12 weeks 12 weeks 12-16 weeks	Non-cirrhotic & compensated cirrhosis (Child-Pugh A) Decompensated cirrhosis (Child-Pugh B & C) *16 weeks = cirrhotic pts	
	Genotype 3	Epclusa Epclusa + RBV Sovaldi + Daklinza		12 weeks 12 weeks 12 weeks
	Genotype 4	Epclusa Epclusa + RBV Harvoni		12 weeks 12 weeks 12 weeks
Zepatier		12 weeks		
Zepatier + RBV		16 weeks		
Technivie + RBV		12 weeks		
Technivie		12 weeks		
Genotype 5+6		Epclusa Epclusa + RBV Harvoni	12 weeks 12 weeks 12 weeks	

TREATMENT REGIMEN & PRESCRIPTION

	MEDICATION	STRENGTH	DIRECTIONS	DISPENSE QTY	DURATION
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	
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	
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.

<input type="checkbox"/> Prescriber Name: _____	DEA: _____	NPI: _____	<input type="checkbox"/> Prescriber Name: _____	DEA: _____	NPI: _____
<input type="checkbox"/> Prescriber Name: _____	DEA: _____	NPI: _____	<input type="checkbox"/> Prescriber Name: _____	DEA: _____	NPI: _____
<input type="checkbox"/> Prescriber Name: _____	DEA: _____	NPI: _____	<input type="checkbox"/> Prescriber Name: _____	DEA: _____	NPI: _____

Address: _____ Phone: _____ Fax: _____ Contact Person: _____

Date: _____ Provider Signature: _____ Do not substitute