Dolphin Health Rx
Committed to Helping People Get Well

HEPATITIS C ENROLLMENT & RX FORM

Toll Free: 844-436-5744
Local Phone: 510-900-3131
Fax: 844-329-6979

PATIENT INFORMATION

Written Date:

Ship To:
- ☐ Patient (All Fills)
- ☐ Provider (1st Fill Only)
- ☐ Provider (All Fills)
- ☐ Other: _____

Patient Name:
Date of Birth:
SSN:
Address:
City, State, Zip Code:
Phone:
Email Address:
Preferred language:
Contact Person:

ENROLLMENT CHECKLIST

PLEASE PROVIDE FOR ALL PATIENTS

- ☐ Demographics
- ☐ Insurance cards
- ☐ Last 2 visit notes
- ☐ HCV Genotype
- ☐ HCV RNA (Last 90 days)
- ☐ CBC w/ PLT (Last 90 days)
- ☐ Complete Metabolic Panel (Last 90 days)
- ☐ Fibrosis documentation (Biopsy, Fibroscan, Fibrosure)
- ☐ Imaging (*if available)
- ☐ PT/INR (*if cirrhotic)
- ☐ NS5A and/or NS3A Resistance Testing
- ☐ Current Med List
- ☐ Pt adherence/readiness documentation

DIAGNOSIS INFORMATION (Please include supporting documents)

Diagnosis:
- ☐ B18.2 Hepatitis C
- ☐ HCV/HIV Co-infection
- ☐ HCV/HBV Co-infection
- ☐ HCC
- ☐ Pre/post- transplant

Height: _____
Weight: _____

Genotype:
- ☐ 1A ☐ 4
- ☐ 1B ☐ 5
- ☐ 2 ☐ 6
- ☐ 3
- ☐ Other: _____

Allergies: _____

Prior treatment history:
- ☐ Naïve ☐ Relapser ☐ Non-Responder
- ☐ Discontinued due to side effects

Prior treatment regimen:
- ☐ RBV ☐ IFN ☐ Harvoni ☐ Sovaldi
- ☐ Olysio ☐ Incivek ☐ Victrelis ☐ Other: _____

Stage of Fibrosis
- ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4 APRI score: _____

HIGH PRIORITY FOR TREATMENT

(Please select all that apply)
Please include labs and/or notes

COMORBIDITIES
- ☐ HIV co-infection
- ☐ HBV co-infection
- ☐ Type 2 DM
- ☐ Debilitating fatigue

EXTRAHEPATIC MANIFESTATIONS
- ☐ Porphyria cutanea carda
- ☐ 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

CURRENT TREATMENT REGIMENS

Genotype	Available Regimens	Duration	Notes
Genotype 1	**Epclusa**	12 weeks	Non-cirrhotic & compensated cirrhosis (Child-Pugh A)
	Epclusa + RBV	12 weeks	Decompensated cirrhosis (Child-Pugh B & C)
	Harvoni	8 weeks	8 wks =Tx naïve, w/o cirrhosis, baseline VL < 6 million
		12 weeks	12 wks = Tx naïve w/cirrhosis & tx experienced w/o cirrhosis
		24 weeks	24 wks = Tx experienced w/ cirrhosis GT 1b w/o cirrhosis
	Zepatier	12 weeks	Tx naïve or IFN/RBV-experienced without baseline NS5A polymorphisms (GT1a) or Tx naïve or IFN/RBV-experienced (GT1b)
	Zepatier + RBV	12 weeks	GT1a or GT1b, IFN/RBV/PI-experienced
	Zepatier + RBV	16 weeks	GT1a, tx naïve or IFN/RBV-experienced with baseline NS5A polymorphisms
	Viekira XR	12 weeks	GT1b w/ or w/o compensated cirrhosis
	Viekira XR + RBV	12 weeks	GT1a w/o cirrhosis
	Viekira XR + RBV	24 weeks	GT1a w/ compensated cirrhosis
Genotype 2	**Epclusa**	12 weeks	Non-cirrhotic & compensated cirrhosis (Child-Pugh A)
	Epclusa + RBV	12 weeks	Decompensated cirrhosis (Child-Pugh B & C)
	Sovaldi + RBV	12-16 weeks	*16 weeks = cirrhotic pts
Genotype 3	**Epclusa**	12 weeks	Non-cirrhotic & compensated cirrhosis (Child-Pugh A)
	Epclusa + RBV	12 weeks	Decompensated cirrhosis (Child-Pugh B & C)
	Sovaldi + Daklinza	12 weeks	
Genotype 4	**Epclusa**	12 weeks	Non-cirrhotic & compensated cirrhosis (Child-Pugh A)
	Epclusa + RBV	12 weeks	Decompensated cirrhosis (Child-Pugh B & C)
	Harvoni	12 weeks	
	Zepatier	12 weeks	Treatment naïve
	Zepatier + RBV	16 weeks	IFN/RBV-experienced
	Technivie + RBV	12 weeks	Non-cirrhotic
	Technivie	12 weeks	Tx naïve, non-cirrhotic, who cannot take ribavirin
Genotype 5+6	**Epclusa**	12 weeks	Non-cirrhotic & compensated cirrhosis (Child-Pugh A)
	Epclusa + RBV	12 weeks	Decompensated cirrhosis (Child-Pugh B & C)
	Harvoni	12 weeks	

TREATMENT REGIMEN & PRESCRIPTION

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

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: _____
DEA: _____ NPI: _____
Phone: _____ Fax: _____
Address: _____
City, State, ZIP Code: _____
Contact Person: _____

Date: _____ **Provider Signature:** _____ ☐ **Do not substitute**