

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Preferred Phone: _____
 SSN#: _____ Language: English Other _____
 Address: _____ Sex: Male Female Height: _____ Weight: _____ lbs kg
 City: _____ State: _____ Zip: _____ Known Allergies: _____

*** PLEASE FAX FRONT/BACK COPY OF PHARMACY BENEFIT CARD, MEDICAL INSURANCE CARD, NOTES, LABS & TESTS WITH THE PRESCRIPTION TO EXPEDITE PROCESSING ***

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
 Address: _____ Phone: _____ E-mail: _____
 City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: _____ Fax: _____
 STATUS UPDATE PREFERENCE: Phone Text Fax E-mail: _____

DIAGNOSIS/CLINICAL INFORMATION

Diagnosis/ICD-10 Code: B18.2 Other: _____ Genotype: _____ Viral Load: _____ NS5A: _____ GFR: _____
 Response Status: Naive Null Partial Prior Treatment Regimen, Date, Reason for DC: _____
 Cirrhosis: Yes No (Compensated Decompensated) Fibrosis Score: _____ Reason for RBV Ineligibility: _____
 Comorbidities: HIV HBV Diabetes CKD ESRD Other: _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	SIG	QTY.	REFILLS																								
EPCLUSA®	400 mg/100 mg	Take 1 tablet by mouth daily with or without food. <table border="1"> <tr><th>PATIENT POPULATION</th><th>TREATMENT</th><th>DURATION</th></tr> <tr><td>GT1-6: w/o Cirrhosis and compensated Cirrhosis (Child-Pugh A)</td><td>EPCLUSA</td><td>12 weeks</td></tr> <tr><td>GT1-6: with decompensated Cirrhosis (Child-Pugh B or C)</td><td>EPCLUSA + RBV</td><td>12 weeks</td></tr> </table>	PATIENT POPULATION	TREATMENT	DURATION	GT1-6: w/o Cirrhosis and compensated Cirrhosis (Child-Pugh A)	EPCLUSA	12 weeks	GT1-6: with decompensated Cirrhosis (Child-Pugh B or C)	EPCLUSA + RBV	12 weeks	28-day supply																
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HARVONI®	90 mg/400 mg	Take 1 tablet by mouth daily with or without food. <table border="1"> <tr><th>DURATION OF THERAPY GUIDANCE FOR CHC GT1</th><th>DURATION</th><th>REFILLS</th></tr> <tr><td>Naive Non-Cirrhotic HCV RNA >6 million IU</td><td>12 weeks</td><td>2</td></tr> <tr><td>Naive Non-Cirrhotic HCV RNA <6 million IU</td><td>8 weeks</td><td>1</td></tr> <tr><td>Naive Non-Cirrhotic and Cirrhotic</td><td>12 weeks</td><td>2</td></tr> <tr><td>Non-Responder Non-Cirrhotic</td><td>12 weeks</td><td>2</td></tr> <tr><td>Non-Responder Cirrhotic</td><td>24 weeks</td><td>5</td></tr> </table>	DURATION OF THERAPY GUIDANCE FOR CHC GT1	DURATION	REFILLS	Naive Non-Cirrhotic HCV RNA >6 million IU	12 weeks	2	Naive Non-Cirrhotic HCV RNA <6 million IU	8 weeks	1	Naive Non-Cirrhotic and Cirrhotic	12 weeks	2	Non-Responder Non-Cirrhotic	12 weeks	2	Non-Responder Cirrhotic	24 weeks	5	28-day supply							
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MAVIRET™	100 mg/40 mg	Three tablets (total daily dose: glecaprevir 300 mg and pibrentasvir 120 mg) taken orally once daily with food. <table border="1"> <tr><th>GENOTYPE</th><th>Previously Treated with a Regimen Containing:</th><th>No Cirrhosis</th><th>Compensated Cirrhosis (Child-Pugh A)</th></tr> <tr><td>1, 2, 3, 4, 5 or 6</td><td>Treatment-Naive Patients</td><td>8 weeks</td><td>12 weeks</td></tr> <tr><td>1</td><td>Ledipasvir and Sofosbuvir or Daclatasvir with PEG-INF and Ribavirin</td><td>16 weeks</td><td>16 weeks</td></tr> <tr><td>1</td><td>Simeprevir and Sofosbuvir, or Simeprevir, Boceprevir, or Telaprevir with PEG-INF and Ribavirin</td><td>12 weeks</td><td>12 weeks</td></tr> <tr><td>1, 2, 4, 5 or 6</td><td>Prior treatment experience with regimens containing INF, PEG-INF, Ribavirin, and/or Sofosbuvir, but no prior treatment experience with an HCV NS3/4A PI or NS5A inhibitor</td><td>8 weeks</td><td>12 weeks</td></tr> <tr><td>3</td><td></td><td>16 weeks</td><td>16 weeks</td></tr> </table>	GENOTYPE	Previously Treated with a Regimen Containing:	No Cirrhosis	Compensated Cirrhosis (Child-Pugh A)	1, 2, 3, 4, 5 or 6	Treatment-Naive Patients	8 weeks	12 weeks	1	Ledipasvir and Sofosbuvir or Daclatasvir with PEG-INF and Ribavirin	16 weeks	16 weeks	1	Simeprevir and Sofosbuvir, or Simeprevir, Boceprevir, or Telaprevir with PEG-INF and Ribavirin	12 weeks	12 weeks	1, 2, 4, 5 or 6	Prior treatment experience with regimens containing INF, PEG-INF, Ribavirin, and/or Sofosbuvir, but no prior treatment experience with an HCV NS3/4A PI or NS5A inhibitor	8 weeks	12 weeks	3		16 weeks	16 weeks	28-day supply	
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RIBAVIRIN®	200 mg		28-day supply																									
VIEKIRA PAK® VIEKIRA XR™	12.5/75/50/250 mg 200/8.33/50/33.33 mg	VIEKIRA PAK® Take as directed with a meal. VIEKIRA XR™ 3 tablets taken by mouth once daily with a meal. (Follow GT1 dosing in patients with unknown GT1 subtype or mixed GT. Viekira Pak w/ RBV for 12 weeks may be considered based upon prior treatment history) <table border="1"> <tr><th>PATIENT POPULATION</th><th>TREATMENT</th><th>DURATION</th><th>REFILLS</th></tr> <tr><td>GT1a w/o Cirrhosis</td><td>Viekira Pak w/ RBV</td><td>12 weeks</td><td>2</td></tr> <tr><td>GT1a w/ Cirrhosis</td><td>Viekira Pak w/ RBV</td><td>24 weeks</td><td>5</td></tr> <tr><td>GT1b w/ and w/o Cirrhosis</td><td>Viekira Pak</td><td>12 weeks</td><td>2</td></tr> </table>	PATIENT POPULATION	TREATMENT	DURATION	REFILLS	GT1a w/o Cirrhosis	Viekira Pak w/ RBV	12 weeks	2	GT1a w/ Cirrhosis	Viekira Pak w/ RBV	24 weeks	5	GT1b w/ and w/o Cirrhosis	Viekira Pak	12 weeks	2	28-day supply									
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VOSEVI™	400/100/100 mg	Take 1 tablet by mouth once daily with food. <table border="1"> <tr><th>GENOTYPE</th><th>PATIENTS PREVIOUSLY TREATED WITH AN HCV REGIMEN CONTAINING:</th><th>DURATION</th></tr> <tr><td>1, 2, 3, 4, 5, or 6</td><td>An NS5A inhibitor</td><td>12 weeks</td></tr> <tr><td>1a or 3</td><td>Sofosbuvir without an NS5A inhibitor</td><td>12 weeks</td></tr> </table>	GENOTYPE	PATIENTS PREVIOUSLY TREATED WITH AN HCV REGIMEN CONTAINING:	DURATION	1, 2, 3, 4, 5, or 6	An NS5A inhibitor	12 weeks	1a or 3	Sofosbuvir without an NS5A inhibitor	12 weeks	28-day supply																
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ZEPATIER™	50 mg/100 mg	Take 1 tablet by mouth daily with or without food if taken without RBV. <table border="1"> <tr><th>PATIENT POPULATION</th><th>TREATMENT</th><th>DURATION</th></tr> <tr><td>GT1a: Treatment-naive or PegIFN/RBV- experienced without baseline NS5A polymorphisms</td><td>ZEPATIER</td><td>12 weeks</td></tr> <tr><td>GT1a: Treatment-naive or PegIFN/RBV- experienced with baseline NS5A polymorphisms</td><td>ZEPATIER + RBV</td><td>16 weeks</td></tr> <tr><td>GT1b: Treatment-naive or PegIFN/RBV- experienced</td><td>ZEPATIER</td><td>12 weeks</td></tr> <tr><td>GT1a or 1b: PegIFN/RBV/PI-experienced</td><td>ZEPATIER + RBV</td><td>12 weeks</td></tr> <tr><td>GT4: Treatment-naive</td><td>ZEPATIER</td><td>12 weeks</td></tr> <tr><td>GT4: PegIFN/RBV-experienced</td><td>ZEPATIER + RBV</td><td>16 weeks</td></tr> </table>	PATIENT POPULATION	TREATMENT	DURATION	GT1a: Treatment-naive or PegIFN/RBV- experienced without baseline NS5A polymorphisms	ZEPATIER	12 weeks	GT1a: Treatment-naive or PegIFN/RBV- experienced with baseline NS5A polymorphisms	ZEPATIER + RBV	16 weeks	GT1b: Treatment-naive or PegIFN/RBV- experienced	ZEPATIER	12 weeks	GT1a or 1b: PegIFN/RBV/PI-experienced	ZEPATIER + RBV	12 weeks	GT4: Treatment-naive	ZEPATIER	12 weeks	GT4: PegIFN/RBV-experienced	ZEPATIER + RBV	16 weeks	28-day supply				
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GT4: PegIFN/RBV-experienced	ZEPATIER + RBV	16 weeks																										

Deliver To: Patient Home MD Office
 Prescriber Signature: (Please sign and date below)
 Your signature authorizes Kings Care Pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

Substitution Permissible _____ Date _____ Dispense as written "DAW" _____ Date _____
 IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. 382_HepCRef100-13NY-B