KINGS PHARMACY

HEPATITIS C ENROLLMENT FORM

Kings Pharmacy 33 Park Avenue Newark, NJ 07104 Phone: 888-644-8633 Fax: 800-922-5150

DATE _____ NEEDS BY DATE _____ SHIP TO ○ Patient ○ Office

PATIENT INFORMATION

(Complete the following or send patient demographic sheet)

Patient Name _____ Date of Birth ____ /____ /____ Sex: ○ Male ○ Female
Address _____ City _____ State _____ Zip _____
Home Phone _____ Alternate Phone _____ Social Security # _____

PRESCRIBER INFORMATION

Prescriber's Name _____ DEA # _____ NPI# _____
Address _____ City _____ State _____ Zip _____
Phone _____ Fax _____

INSURANCE INFORMATION

(Please copy and attach the front and back of insurance and prescription drug card)

Prescription Card Name of Insurer _____ ID# _____ BIN _____ PCN _____ Group _____
Primary Insurance Subscriber _____ ID# _____
Is the Patient eligible for Medicare? ○ Yes ○ No

STATEMENT OF MEDICAL NECESSITY

(Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization)

Diagnosis/ICD-9: ○ Hepatitis C 070.54 ○ Cirrhosis ○ Other _____
Comorbidities _____
○ NKDA ○ Known drug allergies _____
Current weight _____ kg/lbs Date recorded _____
HCV genotype: ○ 1 ○ 2 ○ 3 ○ 4 Other _____
Is the patient on or has he or she previously been on interferon/ribavirin therapy? ○ Yes ○ No, naïve to treatment
If yes, name the product(s) and date range(s) of treatment and outcome (if applicable) _____
_____
Responder status: ○ Partial responder ○ Null responder ○ Relapser
For hepatitis C diagnosis: If patient is not on combination therapy using a pegylated interferon with ribavirin, please state the reason _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH/DIRECTIONS	QTY.
○ Pegasys® (peginterferon alfa-2a)	□ 180 mcg/1 mL vial □ 180 mcg/0.5 mL ProClick™ Autoinjector kit of 4 □ 180 mcg/0.5 mL prefilled syringe kit of 4 □ 135 mcg/0.5 mL ProClick™ Autoinjector kit of 4	□ 1 month □ 3 months □ Other
○ PEG-Intron® (peginterferon alfa-2b)	□ 50 mcg □ 80 mcg □ 120 mcg □ 150 mcg	□ Vial □ REDIPEN®
○ Ribavirin	□ 200 mg tablet □ 200 mg capsule	
○ Riba-pak® (ribavirin)	□ 600 mg/day □ 800 mg/day □ 1,000 mg/day □ 1,200 mg/day	
○ Incivek® (telaprevir) 375 mg tablet	750 mg (two 375 mg tablets) by mouth three times a day (7 to 9 hours apart) with food (not low fat)	□ 1 month □ 3 months □ Other
○ Victrelis® (boceprevir) 200 mg capsule	800 mg (four 200 mg capsules) by mouth three times a day (7 to 9 hours apart) with food	□ 1 month □ 3 months □ Other
○ Solvadi® (sofosbuvir) 400 mg capsule	Take one (400 mg) tablet once daily Duration: 12 weeks _____ 24 weeks _____ Other_____	□ 1 month □ 3 months □ Other
○ Olysio™ (simeprevir) 150 mg capsule	Take one (150 mg) capsule once daily with food	□ 1 month □ 3 months □ Other
○ Other medication		□ 1 month □ 3 months □ Other

○ Please enroll my patient into the following manufacturer support program: _____

I hereby freely and voluntarily have selected Kings Pharmacy to dispense the medication herin prescribed by my physician.
Patient Signature: _____

PHYSICAN'S SIGNATURE

_____
REFILLS

_____ _____
PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)