

# HEPATITIS C PRESCRIPTION FORM

Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

**altScripts Specialty Pharmacy**  
 1636 Miller Park Way, West Milwaukee, WI 53214  
 Phone: 414-385-9500 Fax: 414-385-7200  
 altScripts.com



Patient Information: please provide a copy of the patient's insurance card or information					
Patient name:		DOB:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M	HT:	WT:
Address:		City:	State:	Zip Code:	Phone:
Insurance:	Subscriber's name:		ID#:	Group #:	
Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> List allergies:					
Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests and previous medical history to expedite prior authorization					
Diagnosis / ICD-10:		Cirrhosis: <input type="checkbox"/> Compensated <input type="checkbox"/> Decompensated <input type="checkbox"/> None		Viral Load (date):	
Genotype:	Child-Pugh Class:	Fibrosis Score:	<input type="checkbox"/> Post liver transplant	<input type="checkbox"/> Hepatocellular carcinoma	HIV Status:
<input type="checkbox"/> Patient is treatment naïve					
Prior Treatment (dates):					
Prescription					
Medication / Strength	Recommended Dosing Guidelines	Directions / Quantity / Refills			
<input type="checkbox"/> <b>Epclusa®</b> (sofosbuvir 400 mg / velpatasvir 100 mg tablet)	Genotypes 1-6, without cirrhosis and patients with compensated cirrhosis (Child-Pugh A); 12 weeks  Genotypes 1-6, patients with decompensated cirrhosis (Child-Pugh B and C): + RBV; 12 weeks	<input type="checkbox"/> Take 1 tablet PO once daily with or without food Qty:                      Refills:			
<input type="checkbox"/> <b>Harvoni®</b> (ledipasvir / sofosbuvir 90 mg / 400 mg tablet)	Genotype 1, Treatment naïve, non-cirrhotic HCV RNA < 6 million IU; 8 weeks Genotype 1, Treatment naïve, non-cirrhotic & cirrhotic; 12 weeks * Genotype 1, Treatment experienced, non-cirrhotic: +/- RBV; 12 weeks	<input type="checkbox"/> Take 1 tablet PO once daily <input type="checkbox"/> Other:  Qty:                      Refills:			
<small>* add RBV recommended when Tx experienced was SOF + RBV +/- IFN ** Genotype 4, Tx experienced, cirrhotic: with RBV for 12 weeks or without RBV for 24 weeks</small>	<small>* Genotype 1, Treatment experienced, cirrhotic: +/- RBV; 12-24 weeks ** Genotype 4, 5, 6, non-cirrhotic &amp; cirrhotic; 12 weeks</small>				
<input type="checkbox"/> <b>Mavyret™</b> (glecaprevir 100 mg and pibrentasvir 40 mg tablet)	Genotypes 1-6, Treatment naïve, non-cirrhotic (8 weeks) and compensated cirrhosis, Child-Pugh A (12 weeks) Genotype 1, Treatment experienced with an NS5A inhibitor without prior treatment with an NS3/4A protease inhibitor; 16 weeks Genotype 1, Treatment experienced with an NS3/4A protease inhibitor, without prior treatment with an NSA inhibitor; 12 weeks Genotypes 1, 2, 4, 5 or 6, Treatment experienced with a regimen containing PRS; non-cirrhotic (8 weeks) and compensated cirrhosis, Child-Pugh A (12 weeks) Genotype 3, Treatment experienced with a regimen containing PRS; 16 weeks	<input type="checkbox"/> Take 3 tablets PO once daily, with food  Qty:                      Refills:			
<input type="checkbox"/> <b>Olysio®</b> (simeprevir 150 mg capsule)	Genotype 1, non-cirrhotic: SIM + SOF; 12 weeks Genotype 1, cirrhotic: SIM + SOF +/- RBV (Q80K-); 24 weeks	<input type="checkbox"/> Take 1 capsule PO once daily Qty:                      Refills:			
<input type="checkbox"/> <b>Ribavirin</b> 200 mg tablet	<input type="checkbox"/> Take _____ mg qAM and _____ mg qPM	Qty:                      Refills:			
<input type="checkbox"/> <b>Sovaldi®</b> (sofosbuvir 400 mg tablet)	Genotype 1 or 3, non-cirrhotic: DAC + SOF; 12 weeks Genotype 1 or 3, cirrhotic: DAC + SOF +/- RBV; 24 weeks Genotype 2, non-cirrhotic: SOF + RBV; 12 weeks Genotype 2, non-cirrhotic, RBV ineligible: DAC + SOF; 12 weeks Genotype 2, cirrhotic: SOF + RBV; 16-24 weeks Genotype 2, cirrhotic: SOF + RBV + IFN; 12 weeks Genotype 2, cirrhotic, RBV ineligible: DAC + SOF; 16-24 weeks Genotype 3, non-cirrhotic & cirrhotic, DAC + IFN ineligible: SOF + RBV; 24 weeks Genotype 3, 4, 5 or 6, non-cirrhotic & cirrhotic: SOF + RBV + IFN; 12 weeks	<input type="checkbox"/> Take 1 tablet PO once daily <input type="checkbox"/> Other:  Qty:                      Refills:			
<input type="checkbox"/> <b>Vosevi™</b> (sofosbuvir 400 mg / velpatasvir 100 mg / voxilaprevir 100 mg tablet)	Genotypes 1-6 without cirrhosis or with mild cirrhosis; 12 weeks	<input type="checkbox"/> Take 1 tablet PO once daily, with food  Qty:                      Refills:			
<input type="checkbox"/> <b>Zepatier™</b> (elbasvir 50 mg / grazoprevir 100 mg tablet)	Genotype 1a, without baseline polymorphisms; 12 weeks Genotype 1a, with NS5A polymorphisms: + RBV; 16 weeks Genotype 1b: 12 weeks Genotype 1a or 1b, PI experienced: + RBV; 12 weeks Genotype 4, Treatment naïve; 12 weeks Genotype 4, Treatment experienced: + RBV; 16 weeks	<input type="checkbox"/> Take 1 tablet PO once daily <input type="checkbox"/> Other:  Qty:                      Refills:			
<input type="checkbox"/> <b>Other medication(s):</b>					
Prescriber Information					
Prescriber name:		Phone:		Office contact name:	
Prescriber address:		City:		State:	Zip:
NPI:	DEA:	Fax and/or Email:			
Prescriber signature:		Date:		<input type="checkbox"/> DO NOT SUBSTITUTE	

Important Notice: This facsimile transmission is intended to be delivered only to the named recipient(s), and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named recipient, immediately notify the sender at the address and phone number set forth herein and obtain instructions as to properly dispose of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except authority of the sender to the named addressee.