HEPATITIS C
ENROLLMENT FORM
Fax: 270-247-6033 or 270-251-3571

DUNCAN
SPECIALTY PHARMACY

317 W. Broadway
Mayfield, KY 42066
Phone: 270-247-3725

Today's Date: Needs by Date: Ship to: ☐Patient ☐Office ☐Other:

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Home & Cell #:		DEA #:	State Lic#:
SSN:		NPI#:	
DOB:	Sex:	Phone:	Fax:
Patient Weight:	lbs or KG	Contact Person Name:	
Drug Allergies:		Contact E-mail:	

INSURANCE INFORMATION: Please fax front & back copy of Medical & Prescription card(s) if possible as well as pertinent chart notes related to Patient's diagnosis.

Clinical Information—Statement Of Medical Necessity

Diagnostic Information & Prior Treatment History

Diagnosis: Hepatitis C Cirrhosis	Patient Weight: Patient Height:
Genotype: 1 2 3 4 5 6 Subtype: Viral Load:	Liver Biopsy: Y or N Date:
Naive: Relapsed*:	State: Grade:
Partial Responder*:	Creatine: Date:
*Please provide dates of previous treatment & viral load	HIV Status:
Results:	

Prescription Information

✓	MEDICATION/DOSE		DIRECTIONS	QTY	REFILLS
☐	RIBA-PAK	☐600mg/600mg ☐600mg/400mg ☐400mg/400mg ☐200mg/400mg	☐1200mg/day: 600mg Q AM & Q PM ☐1000mg/day: 600mg Q AM & 400mg Q PM ☐800mg/day: 400mg Q AM & Q PM ☐600mg/day: 400mg Q AM & 200mg Q PM		
☐	RIBAVIRIN	☐200mg Tablet ☐200mg Capsule	Take _____ tabs/caps Q AM & _____tabs/caps Q PM		
☐	DAKLINZA	☐30mg Tablet ☐60mg Tablet	Take 1 tablet by mouth once a day Take 90mg by mouth once a day		
☐	SOVALDI	400 mg Tablet	Take 1 tablet by mouth once a day for: ☐12 Weeks ☐24 Weeks		
☐	OLYSIO	50 mg Capsule	Take once daily with food		
☐	HARVONI	90mg/400mg	Take 1 tablet by mouth once a day for: ☐12 Weeks ☐24 Weeks		
☐	VIEKIRA PAK	12.5/75/50mg ombitasvir, paritaprevir, ritonavir 250mg dasabuvir tablets	Take per pack directions. 3 tabs in AM & 1 tab in PM for: ☐12 Weeks ☐24 Weeks		
☐	ZEPATIER	50/100mg	Take once daily with or without food		
☐	EPCLUSA	400/100mg	Take once daily		
☐	TECHNIVIE PAK		Take 2 tablets in the morning with a meal per pack directions		

By signing this form & utilizing our services, you are authorizing Duncan Specialty Pharmacy & its employees to serve as your prior authorization designated agent in dealing with medical & prescription insurance companies. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials to another pharmacy of the patient's choice or within his/her provider network.

Prescriber Signature: _____Date: _____