CenterWell Specialty Pharmacy

Fax: 877-405-7940
Phone: 800-486-2668

CenterWell Specialty Pharmacy™

Monday – Friday, 8 a.m. – 11 p.m., and
Saturday, 8 a.m. – 6:30 p.m., Eastern time

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

Hepatitis C Prescription Form

Patient information

Patient: _____ ❒ Female ❒ Male DOB: _____ Height: _____ Weight: _____ ❒ lb ❒ kg Date: _____

Address: _____ City: _____ State: _____ ZIP code: _____

Home phone #: _____ Cell phone #: _____ Caregiver: _____ Caregiver phone #: _____

Other medical conditions: _____ Allergies: ❒ No ❒ Yes: _____

Insurance plan: _____ Plan ID #: _____ BIN: _____ PCN: _____ Group #: _____

*Please send a copy of the patient's prescription insurance card if available.

Clinical information

ICD-10 code: _____ Genotype: _____ Baseline viral load: _____ Date obtained: _____

Is the patient interferon eligible? ❒ Yes ❒ No *If "No," why not?*_____

Patient type: ❒ Naive ❒ Relapse ❒ Partial responder ❒ Null responder

Renal impairment: ❒ No ❒ Yes *If "Yes," indicate the CKD stage:* ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ 5

Cirrhosis: ❒ No ❒ Yes *If "Yes":* ❒ Compensated ❒ Decompensated

HIV coinfection: ❒ No ❒ Yes

History of renal transplant: ❒ No ❒ Yes

History of liver transplant: ❒ No ❒ Yes Reinfection: ❒ No ❒ Yes

If applicable, please provide each previous therapy and its dates:

Therapy:	Discontinuation reason:	Dates:
❒ _____	_____	_____
❒ _____	_____	_____

Prescription information

Note: Ohio law allows one prescription per preprinted order form. Please use additional forms for more than one prescription.

Medication	Dose	Directions	Quantity	Refills
❒ Epclusa	❒ 400 mg/100 mg tablets ❒ 200 mg/50 mg tablets ❒ 200 mg/ 50mg oral granules ❒ 150 mg/ 37.5mg oral granules	❒ Take one tablet daily ❒ Take one packet daily as directed ❒ _____	4 weeks	_____
❒ Harvoni	❒ 90 mg/400 mg tablets ❒ 45 mg/200 mg tablets ❒ 45 mg/200 mg oral pellets ❒ 33.75mg/150mg oral pellets	❒ Take one tablet daily ❒ Take one packet daily as directed ❒ _____	4 weeks	_____
❒ Mavyret	100 mg/40 mg	❒ Take three tablets once daily with food	4 weeks	_____
❒ Ribavirin	❒ 200 mg tablets ❒ 200 mg capsules	❒ Take 600 mg in the morning and 600 mg in the evening ❒ Take 600 mg in the morning and 400 mg in the evening	4 weeks	_____
❒ Sovaldi	400 mg	❒ Take one tablet daily	4 weeks	_____
❒ Vosevi	400 mg/100 mg/100 mg	❒ Take one tablet daily with food	4 weeks	_____
❒ Zepatier	50 mg/100 mg	❒ Take one tablet daily with or without food	4 weeks	_____
❒ _____	_____	_____	_____	_____

Prescriber and shipping information (please print)

Prescriber: _____ NPI: _____

Ship to: ❒ Patient ❒ Office ❒ Other: _____

Office address: _____ City: _____ State: _____ ZIP code: _____

Office phone number: _____ Office fax number: _____

Signature: _____ Date: _____

We will dispense this prescription as generic, unless the prescriber indicates "Dispense as Written" here: _____

The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form and fax language. Noncompliance with state-specific requirements could result in outreach to the prescriber.