Publix Specialty Pharmacy #3213

HEPATITIS C VIRUS: ADULT

1950 Sand Lake Road, Bldg 5
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: _____ Patient's Last Name: _____

Date of Birth: _____/_____/_____ ☐ Male ☐ Female Caregiver Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: (_____) _____ Alt. Phone Number: (_____) _____

Clinical Information [Attach copy of labs and clinical notes] ☐ Urgent Request Using Cover My Meds: ☐No ☐Yes

Diagnosis code: ☐B18.2 ☐Other: _____ Genotype and subtype: _____ Height: _____ ☐cm ☐ in

Treatment status: ☐Naïve ☐Experienced, prior therapy: _____ Weight: _____ ☐kg ☐lb

Treatment duration (weeks): ☐8 ☐12 ☐16 ☐24 ☐Other: _____ Co-infections: ☐None ☐HIV ☐Hep B ☐Other: _____

CrCl _____ mL/min Baseline viral load (VL): _____ Date of VL: _____/_____/_____ SCr: _____ mg/dL, Date of SCr: _____/_____/_____

Fibrosis score: ☐0 ☐1 ☐2 ☐3 ☐4 Cirrhosis: ☐No ☐Compensated ☐Decompensated

Other pertinent past medical history and/or drug therapy: _____

Allergies: ☐ NKDA ☐Other: _____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY (28 days)	REFILLS
☐ Epclusa (velpatasvir/ sofosbuvir)	400/100 mg tablet	Take 1 tab PO one time daily	28	_____
☐ Harvoni (ledipasvir/ sofosbuvir)	90/400 mg tablet	Take 1 tab PO one time daily	28	_____
☐ Mavyret (glecaprevir/ pibrentasvir)	100/40 mg tablet	Take 3 tabs PO one time daily with food	84	_____
☐ Ribavirin ☐ Tablet ☐ Capsule *If dosage form not specified, availability or insurance preference will be used*	200 mg Patient weight: _____	☐ ≥75 kg: Take 600 mg PO twice a day with food	168	_____
		☐< 75 kg: Take 600 mg PO in AM and 400mg PO in PM with food	140	_____
		☐Other: _____	_____	_____
☐ Vosevi (velpatasvir/sofosbuvir/ voxilaprevir)	100/400/100 mg tablet	Take 1 tab PO one time daily with food	28	_____
☐ _____	_____	_____	_____	_____

Prescriber Information

Ship to prescriber: ☐ Never ☐Always ☐ First fill only Appointment date: _____/_____/_____

Name: _____ DEA# _____ NPI # _____

Supervising Physician: ☐ Not Applicable ☐ _____ Supervising Physician NPI # _____

Address: _____ City: _____ State: _____ Zip: _____

Office Phone Number: (_____) _____ Fax Number: (_____) _____ Office Contact: _____

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature: _____ _____
(stamps not accepted) ☐Substitution allowed Date ☐Dispense as written/ Do not substitute Date

For states requiring hand written expressions to prevent substitution, write here:

Publix Specialty Pharmacy #3213

HEPATITIS C VIRUS: PEDIATRIC

1950 Sand Lake Road, Bldg 5
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: _____ Patient's Last Name: _____

Date of Birth: ____/____/_____ ☐ Male ☐ Female Caregiver Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: (____) _____ Alt. Phone Number: (____) _____

Clinical Information [Attach copy of labs and clinical notes] ☐ Urgent Request Using Cover My Meds: ☐ No ☐ Yes

Diagnosis code: ☐ B18.2 ☐ Other: _____ Genotype and subtype: _____ Height: _____ ☐ cm ☐ in

Treatment status: ☐ Naïve ☐ Experienced, prior therapy: _____ Weight: _____ ☐ kg ☐ lb

Treatment duration (weeks): ☐ 8 ☐ 12 ☐ 16 ☐ 24 ☐ Other: _____ Co-infections: ☐ None ☐ HIV ☐ Hep B ☐ Other: _____

CrCl _____ mL/min Baseline viral load (VL): _____ Date of VL: _____/_____/_____ SCr: _____ mg/dL, Date of SCr: _____/_____/_____

Fibrosis score: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 Cirrhosis: ☐ No ☐ Compensated ☐ Decompensated

Other pertinent past medical history and/or drug therapy: _____

Allergies: ☐ NKDA ☐ Other: _____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY (28 days)	REFILLS
☐ Epclusa (velpatasvir/ sofosbuvir)	☐ 150/37.5 mg pellets	☐ <17 kg: Take 1 packet PO one time daily	28	_____
	☐ 200/50 mg pellets ☐ 200/50 mg tablet	☐ 17 to <30 kg: Take 1 dose PO one time daily		
	☐ 400/100 mg pellets ☐ 400/100 mg tablet	☐ ≥30 kg: Take 1 dose PO one time daily		
☐ Harvoni (ledipasvir/ sofosbuvir)	☐ 33.75/150 mg pellets	☐ < 17 kg: Take 1 packet PO one time daily	28	_____
	☐ 45/200 mg pellets ☐ 45/200 mg tablet	☐ 17 to < 35 kg: Take 1 dose PO one time daily		
	☐ 90/400 mg tablet	☐ ≥ 35 kg: Take 1 tab PO one time daily		
☐ Mavyret (glecaprevir/ pibrentasvir)	☐ 50/20 mg pellets	☐ <20 kg: Take 3 packets PO one time daily with food	84	_____
		☐ 20 to <30 kg: Take 4 packets PO one time daily with food	112	_____
		☐ 30 to <45 kg: Take 5 packets PO one time daily with food	140	_____
	☐ 100/40 mg tablet	☐ ≥45 kg or ≥12 years: Take 3 tabs PO one time daily with food	84	_____

Prescriber Information Ship to prescriber: ☐ Never ☐ Always ☐ First fill only Appointment date: _____/_____/_____

Name: _____ DEA# _____ NPI # _____

Supervising Physician: ☐ Not Applicable ☐ _____ Supervising Physician NPI # _____

Address: _____ City: _____ State: _____ Zip: _____

Office Phone Number: (____) _____ Fax Number: (____) _____ Office Contact: _____

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature: _____ _____
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