

PATIENT INFORMATION

Last Name _____ First Name _____ DOB _____
 Address _____ City _____ State _____ Zip _____
 Gender: Male Female Height _____ Weight _____ Social Security # _____
 Home Phone _____ Cell _____ Email Address _____
 Allergies _____ Emergency Contact Name _____ Phone _____

INSURANCE INFORMATION

Please provide a current copy of insurance card(s) or complete the following information

Primary Insurance _____ Policy # _____ Group # _____ Phone _____
 Policy Holder's Name _____ DOB _____
 Secondary Insurance _____ Policy # _____ Group # _____ Phone _____
 Policy Holder's Name _____ DOB _____

CLINICAL INFORMATION

Primary Diagnosis: _____ Diagnosis Code: _____ HCV Treatment History List previous treatment regimens:
 Naive _____
 Retreatment _____
 Partial Relapse _____
 Secondary Diagnosis: _____ Diagnosis Code: _____
 Viral Load: _____ HIV Positive: Yes No Cirrhosis: Yes No
 Date: _____ Metavir Score: _____ Awaiting Liver Transplant: Yes No
 Genotype: _____ Child-Pugh Score: _____ Liver Status: Compensated Decompensated

MEDICATIONS

<input type="checkbox"/> Daklinza™ (Daclatasvir)	<input type="checkbox"/> 30 mg tablet <input type="checkbox"/> 60 mg tablet	Directions: Take 1 tablet by mouth daily with Sovaldi®	Qty: 28	Refills: _____
<input type="checkbox"/> Harvoni® (Ledipasvir/Sofosbuvir)	90 mg/400 mg tablet	Directions: Take 1 tablet by mouth once daily	Qty: 28	Refills: _____
<input type="checkbox"/> Olysio® (Simeprevir)	150 mg capsule	Directions: Take 1 capsule by mouth once daily with food	Qty: 28	Refills: _____
<input type="checkbox"/> Sovaldi® (Sofosbuvir)	400 mg tablet	Directions: Take 1 tablet by mouth once daily	Qty: 28	Refills: _____
<input type="checkbox"/> Technivie™ (Ombitasvir/Paritaprevir/Ritonavir)	12.5 mg/ 75 mg/ 50 mg tablet	Directions: Take two tablets by mouth every morning with meal	Qty: 56	Refills: _____
<input type="checkbox"/> Viekira Pak™ (Ombitasvir/Paritaprevir/Ritonavir/Dasabuvir)	12.5 mg/75 mg/50 mg/250 mg tablet	Directions: Take 3 tablets by mouth every morning and 1 tablet by mouth every evening (Take both doses with food)	Qty: 112	Refills: _____

Ribavirin 200 mg

Tablet Capsule
 Directions: _____ by mouth every morning
 _____ by mouth every evening

Qty: 28 day supply Refills: _____

RibaPak® (Ribavirin)

RibaPak 800 (400 mg by mouth every morning, 400 mg by mouth every evening)
 RibaPak 1000 (600 mg by mouth every morning, 400 mg by mouth every evening)
 RibaPak 1200 (600 mg by mouth every morning, 600 mg by mouth every evening)

Qty: 28 day supply Refills: _____

Pegasys® ProClick™ (Peginterferon alfa-2a)

135 mcg/0.5 mL 180 mcg/0.5 mL Directions: Inject one pen under the skin weekly Qty: 4 Refills: _____

Other Drug Name: _____ Directions: _____ Qty: _____ Refills: _____

EDUCATION AND DELIVERY INSTRUCTIONS

Education: Cottrill's Specialty Pharmacy to coordinate injection
 training Physician's office to provide injection training

Deliver to: Patient's home Physician's Office
 1st dose to physician's office - remaining to patient home

PHYSICIAN INFORMATION

Physician Name _____ NPI# _____
 License # _____ State _____ DEA# _____
 Address _____ City _____ State _____ Zip _____
 Phone: _____ Fax: _____ Office Contact _____

Product Selection Permitted

Dispense as Written

Date

Cottrill's will verify insurance benefits, initiate PA's and notify patient prior to admission of any out of pocket expenses or co-payments