



Publix Specialty Pharmacy #3213
HEPATITIS C VIRUS

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
 Address: _____ City: _____ State: _____ Zip: _____
 Primary Phone Number: (____) _____ Alt. Phone Number: (____) _____ Caregiver name: _____

CLINICAL INFORMATION [Attach copy of labs/tests and clinical notes] Previously denied by insurance? No Yes, include copy of denial letter

Diagnosis code: B18.2 Other: _____ Genotype and subtype: _____ Baseline viral load (VL): _____ Date of VL: ___/___/___
 Cirrhosis: No Compensated Decompensated Fibrosis score: 0 1 2 3 4 Co-infections: None HIV Hep B Other: _____
 SCR: _____ mg/dL, CrCl _____ mL/min, Date of SCR: ___/___/___ Weight: _____ kg lb Height: _____ cm in
 Treatment status: Naïve Experienced, prior therapy: _____ Treatment duration (weeks): 8 12 16 24 Other: ___
 Other pertinent past medical history and/or drug therapy: _____
 Allergies: NKDA Other: _____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY (28 DAY SUPPLY)	REFILLS
<input type="checkbox"/> Epclusa (velpatasvir/ sofosbuvir)	100/400 mg tablet	Take 1 tab PO once daily with or without food	28	_____
<input type="checkbox"/> Harvoni (ledipasvir/ sofosbuvir)	90/400 mg tablet	Take 1 tab PO once daily with or without food	28	_____
<input type="checkbox"/> Mavyret (glecaprevir/ pibrentasvir)	100/40 mg tablet	Take 3 tabs PO once daily with food	84	_____
<input type="checkbox"/> Vosevi (velpatasvir/ sofosbuvir/ voxilaprevir)	100/400/100 mg tablet	Take 1 tab PO once daily with food	28	_____
<input type="checkbox"/> Zepatier (elbasvir/ grazoprevir)	50/100 mg tablet	Take 1 tab PO once daily with or without food	28	_____
<input type="checkbox"/> Ribasphere (ribavirin) <input type="checkbox"/> Tablet <input type="checkbox"/> Capsule <i>If dosage form not specified, availability or insurance preference will be used.</i>	200 mg (generic) Patient weight: _____	<input type="checkbox"/> >75 kg: Take 600 mg PO BID with food	168	_____
		<input type="checkbox"/> ≤ 75 kg: Take 600 mg PO in AM and 400mg PO in PM with food	140	_____
		<input type="checkbox"/> Other: _____	_____	_____
<input type="checkbox"/>	_____	_____	_____	_____
<input type="checkbox"/>	_____	_____	_____	_____

PRESCRIBER INFORMATION

Ship to prescriber: Never Always First fill only, appointment date: ___/___/___ Using Cover My Meds: No Yes

Name: _____ DEA# _____ 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:

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