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

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: