SPS Specialty Pharmacy Services, Inc.

Contact for Office: 787-704-2025 /2028
FAX: 787-704-2027

HEPATITIS C ENROLLMENT

Patient Information

Patient:_____ Caregiver: _____
SS#:_____ DOB:_____ ☐ Male ☐ Female
Address:_____ City:_____ State:_____ Zip:_____
Best Phone #:_____ ☐ Cell Alternate Phone #:_____ Cell ☐
Weight:_____ kgs or lbs (circle one) Recorded Date:_____ Allergies _____ ☐ NKDA

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

Medical Assessment

Please Complete This Entire Section

Diagnosis: ☐ 070.54 HCV (Chronic) Genotype:_____ Subtype:_____
For genotype 1a, is the Q80K polymorphism present? ☐ Yes ☐ No
Previously treated for HCV? ☐ Yes ☐ No # of weeks:_____
☐ Relapsed ☐ Partial Response ☐ Null Response
Liver biopsy done? ☐ Yes ☐ No Date:_____ Result:_____
Is the patient interferon-intolerant? ☐ Yes ☐ No Is the patient awaiting liver transplantation for hepatocellular carcinoma? ☐ Yes ☐ No

Baseline Labs	Result	Date
Hgb		
ALT		
AST		
HCV RNA		

Interferon

PEGASYS® Qty: 4 doses (28 days) Refill #:_____

☐ ProClick™ 180 mcg Autoinjector, 180 mcg SubQ once weekly
☐ ProClick™ 135 mcg Autoinjector, 135 mcg SubQ once weekly
☐ Prefilled Syringe 180 mcg/0.5 mL, 180 mcg SubQ once weekly
☐ Prefilled Syringe 180 mcg/0.5 mL, 135 mcg SubQ once weekly
☐ Vial 180 mcg/mL, 180 mcg (1 mL) SubQ once weekly
☐ Vial 180 mcg/mL, 135 mcg (0.75 mL) SubQ once weekly

PEG-INTRON® ☐ **REDIPEN®** ☐ **VIAL** ☐ **SELECTDOSE™**

Weight kg (lb)	Dosing *(based on 1.5 mcg/kg/wk with Ribavirin)*
<40 (<88)	☐ 50 mcg (0.5 mL) SubQ weekly
40-50 (88-111)	☐ 64 mcg (0.4 mL) SubQ weekly
51-60 (112-133)	☐ 80 mcg (0.5 mL) Sub-Q weekly
61-75 (134-166)	☐ 96 mcg (0.4 mL) SubQ weekly
76-85 (167-187)	☐ 120 mcg (0.5 mL) SubQ weekly
86-105 (188-231)	☐ 150 mcg (0.5 mL) SubQ weekly
> 105 (>231)	☐ 1.5 mcg/kg/week (may require multiple strengths)

Qty: 4 doses (28 days) Refill #:_____

Ribavirin

☐ **Ribasphere® Ribapak®** ☐ **Moderiba™ Dose Pack**

*To dispense Brand product only, DAW must be written here:*_____

☐ **600 mg/day** – 200 mg q AM and 400 mg q PM Qty: 28 x 200 mg + 28 x 400 mg tabs
☐ **800 mg/day** – 400 mg q AM and 400 mg q PM Qty: 56 x 400 mg tabs
☐ **1000 mg/day** – 400 mg q AM and 600 mg q PM Qty: 28 x 400 mg + 28 x 600 mg tabs
☐ **1200 mg/day** – 600 mg q AM and 600 mg q PM Qty: 56 x 600 mg tabs

Refill #: _____

☐ **Ribasphere® 200 mg Tablet** ☐ **Ribasphere® 200 mg Capsule**
☐ **Moderiba™ 200 mg Tablet**

*To dispense Brand product only, DAW must be written here:*_____

☐ 200 mg q AM and 400 mg q PM Qty: 84 Ref:_____
☐ 400 mg q AM and 400 mg q PM Qty: 112 Ref:_____
☐ 400 mg q AM and 600 mg q PM Qty: 140 Ref:_____
☐ 600 mg q AM and 600 mg q PM Qty: 168 Ref:_____

Protease Inhibitor

☐ **OLYSIO™** (simeprevir) 150 mg
Directions: Take one capsule (150 mg) by mouth once daily with food for 12 weeks.
Quantity: 28 capsules (28 days) Refill #: 2

Polymerase Inhibitor

☐ **SOVALDI™** (sofosbuvir) 400 mg
Directions: Take one tablet (400 mg) by mouth once daily.
Quantity: 28 tablets (28 days)
Refill #: _____

INJECTION TRAINING

☐ SPS Specialty Pharmacy Services Coordinate ☐ Office to Coordinate
RN/LPN to teach administration of injectable to caregiver/patient (in accordance with state laws)

LAB COORDINATION

☐ SPS to Coordinate
(please fill out lab request form)

Prescriber Information

Anticipated Start Date:_____ Prescriber Specialty:_____
Ship to: ☐ Patient ☐ Physician ☐ Clinic ☐ Other:_____
Prescriber: _____ NPI #: _____
Phone #: _____ Fax #: _____ Contact Name: _____
Office Address_____ City: _____ State____ Zip:_____

I authorize SPS Specialty Pharmacy Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process, coordinate and receive patient lab values, and coordinate injection training.

Physician's Signature:_____ Date:_____