BROADWAY SPECIALTY PHARMACY

HEPATOLOGY

Fax: 833.803.3110
Phone: 800.640.8207
broadwayrx.health

1. PATIENT

****PLEASE FAX COPY OF: PRESCRIPTION CARD FRONT & BACK and CLINICAL NOTES/LABS**

NAME:		ADDRESS:	CITY:	STATE:	ZIP:
DOB:	SEX: ☐ F ☐ M	PHONE:	CELL PHONE:	SSN:	
HEIGHT:	WEIGHT:	HIPAA CONTACT/CAREGIVER:	ALLERGIES: ☐ LATEX ☐ NKDA		

2. CLINICAL INFORMATION

DATE OF DIAGNOSIS: _____ HISTORY: ☐ NEW ☐ RESTART | TB TEST: NEGATIVE DATE _____ HBV NEGATIVE OR TREATED: ☐ YES ☐ NO

DIAGNOSIS / ICD-10:	GENOTYPE: ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6	VIRAL LOAD: DATE:
FIBROSIS SCORE:	CIRROSIS: ☐ NONE ☐ COMPENSATED ☐ DECOMPENSATED	CHILD-PUGH: ☐ A ☐ B ☐ C
METAVIR SCORE:	MOST RECENT ALT: _____ AST: _____ DATE:_____	NS3 SENSITIVITY: ☐ REACTIVE ☐ NON-REACTIVE

PREVIOUS TREATMENTS:	END DATE	WEEKS TREATED	RESPONSE STATUS	TRANSPLANT: ☐ YES ☐ NO TYPE: _____	
			☐ NON-RESPONDER ☐ RESPONDER/RELAPSER	NS5A POLYMORPHISM: ☐ YES ☐ NO TYPE:	
			☐ NON-RESPONDER ☐ RESPONDER/RELAPSER	IL-28: ☐ CC ☐ CT ☐ TT	
			☐ NON-RESPONDER ☐ RESPONDER/RELAPSER	IS PATIENT ON A PPI: ☐ YES ☐ NO	☐ HIV CO-INFECTED

3. Rx

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ DAKLINZA®	o 30mg o 60mg o 90mg	o Take 1 tablet by mouth daily, with or without food in combination with sofosbuvir	28 Day Supply	
☐ EPCLUSA® (sofosbuvir/velpatasvir)	o 400mg/100mg	o Take 1 tablet by mouth daily, with or without food	28 Day Supply	
☐ HARVONI® (ledipasvir/sofosbuvir)	o 90mg/400mg	o Take 1 tablet by mouth daily, with or without food	28 Day Supply	
☐ MAVYRET® (glecaprevir/pibrentasvir)	o 100mg/40mg	o Take 3 tablets by mouth daily with food	28 Day Supply	
☐ OLYSIO®	o 150mg	o Take 1 capsule by mouth daily with food	28 Day Supply	
☐ RIBAPAK®	o 400-600mg Pack o 600-600mg Pack	o Take twice daily (600mg AM and 400mg PM) 1000mg/day (142-187lbs) o Take twice daily (600mg AM and 600mg PM) 1200mg/day (188-231lbs)	28 Day Supply	
☐ RIBAVIRIN	o 200mg	o Take twice daily (_____mg AM and _____mg PM)	28 Day Supply	
☐ SOVALDI®	o 400mg	o Take 1 tablet by mouth daily, with or without food	28 Day Supply	
☐ TECHNIVIE® (ombitasvir/paritaprevir/ritonavir)	o 12.5mg/75mg/50mg	o Take 2 tablets by mouth daily with food	28 Day Supply	
☐ VIEKIRA PAK® (ombitasvir,paritaprevir/ritonavir, dasabuvir)	o 12.5mg/75mg/50mg 250mg	o Take 2 tablets (pink) by mouth in the morning and 1 tablet (beige) twice daily in the morning and evening with a meal	28 Day Supply	
☐ VIEKERA XR® (ombitasvir,paritaprevir/ritonavir, dasabuvir)	o 8.33mg/50mg/33.3mg/200mg	o Take 3 tablets by mouth once daily with food	28 Day Supply	
☐ VOSEVI® (sofosbuvir/velpatasvir/voxilaprevir)	o 400mg/100mg/100mg	o Take 1 tablet by mouth daily with food	28 Day Supply	
☐ ZEPATIER® (elbasvir/grazoprevir)	o 50mg/100MG	o Take 1 capsule by mouth daily with or without food	28 Day Supply	
☐				
☐				
☐				

4. PRESCRIBER INFORMATION

UPON PA DENIAL: ☐ SEND FORMULARY ALTERNATIVES ☐ DRAFT APPEAL

PRESCRIBER SIGNATURE:

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. By signing this form and utilizing our services, you are authorizing Broadway Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and Co-Pay Assistance/Foundations.

Signature: _____ Date:_____ Signature:_____ Date: _____

Substitution Permitted — Dispense As Written

PRESCRIBER NAME:	ADDRESS:		CITY:	STATE:	ZIP:
OFFICE CONTACT:	PHONE:	FAX:	NPI:	DEA:	

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