MATRIXVIP

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Questions? E-mail us at **INFO@MATRIX-PHARMACY.COM** or Call **(412) 586-4545**. We are here to assist you!

HEPATITIS C ENROLLMENT FORM

PATIENT INFORMATION & DEMOGRAPHICS

ORDER DATE: _____ **PLANNED START DATE (if known):** _____

LAST NAME: _____ **FIRST NAME:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____

PHONE: _____ **DOB:** _____ ☐ **Female** ☐ **Male**

INSURANCE COMPANY: _____ **ID#:** _____

GROUP#: _____ **EMERGENCY CONTACT:** _____

PRESCRIPTION INFORMATION

DIAGNOSIS: ☐ **B18.2 Chronic Viral Hepatitis C** ☐ **Other:** _____

ALLERGIES: ☐ **NKA** ☐ _____

GENOTYPE: ____ **VIRAL LOAD:** _____ **DATE:** _____ **TX HISTORY:** _____

Drug	Directions	Quantity	Refills
☐ **Mavyret 100mg/40mg**	Take 3 tablets by mouth once daily with food	28 Days Supply	____
☐ **Epclusa 400mg/100mg**	Take 1 tablet by mouth once daily	28 Days Supply	____
☐ **Harvoni 400mg/90mg**	Take 1 tablet by mouth once daily	28 Days Supply	____
☐ **Vosevi 400mg/100mg/100mg**	Take 1 tablet by mouth once daily	28 Days Supply	____
☐ _____	_____	_____	____

PRESCRIBER INFORMATION

OFFICE/CLINIC NAME: _____ **ATTN:** _____

OFFICE ADDRESS: _____

CITY: _____ **STATE:** _____

PHONE: _____ **FAX:** _____

PRESCRIBER NAME _____

NPI: _____ **LICENSE:** _____ **DEA:** _____

PRESCRIBER SIGNATURE: _____ **DATE:** _____

(substitution permissible if applicable)

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE "BRAND NECESSARY" OR "BRAND MEDICALLY NECESSARY" IN THE SPACE BELOW.

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