CompreCare | Rx

Specialty Pharmacy
JCAHO Accredited

HEP C ENROLLMENT FORM

Phone: 800-541-2030
Fax: 888-862-4769

PATIENT INFORMATION		
Patient Name	Male ☐ Female ☐	Allergies NKDA
Date of Birth	SSN#	Weight Kg Lb Date
Address	City	State/Zip
Phone # (Home)	Work #	Email Address
Caregiver	Case Manager	

INSURANCE INFORMATION		
Primary Insurance		Policy Holder
Group #	Policy #	Phone #
Secondary Insurance	Policy #	Phone #

DIAGNOSIS/MEDICAL INFORMATION (PLEASE SPECIFY PRIMARY & SECONDARY DIAGNOSIS)

☐ 070.54 Hepatitis C (Chronic)

☐ Other ICD-10 Genotype: 1 2 3 4

PRESCRIPTION INFORMATION

Medication	Dose	Frequency	Qty	Refills
☐ Intron-A	☐ 3 million units	☐ Inject SQ __ wkly___wks		
☐ Daklinza	☐ 30 mg ☐ 60 mg ☐ 90 mg	☐ Take once daily		
☐ Harvoni	☐ 90 mgledipasvir/400 mg sofosbuvir	☐ Take once daily		
☐ Olysio	☐ 150 mg	☐ Take once daily w/food		
☐ Ribavirin	☐ 200 mg	☐ Take…….mg PO in AM (AM-PM Dose Pak) & ……..mg PO in PM		
☐ Technivie	☐ 12.5/75/50 mg	☐ Take two tablets once daily		
☐ Sovaldi	☐ 400 mg	☐ Take once daily		
☐ Viekira Pak				
☐ Zepatier	☐ 50/100 mg	☐ Take once daily		

DELIVERY INSTRUCTIONS

☐ Physician's Office ☐ Patient's Home ☐ Other

Address Phone #

City/State/Zip Date Medication Needed / /

PHYSICIAN CONTACT INFORMATION & AUTHORIZATION

Physician Name	Phone Fax
Address	City/State/Zip
NPI # DEA #	Office Contact

Physician Signature Date
(signature required to process prescription)