meijer specialty pharmacy

P: 1-855-263-4537 • F: 734-391-2365
www.meijerspecialtypharmacy.com

Hepatitis (T-Z)

Vemlidy®, Vosevi™, Xifaxan®, Zepatier™

Prescriber Information

Ship Meds to: ◯ Patient's Home ◯ Prescriber's Office

Prescriber Name:			◯MD ◯DO ◯NP ◯PA	NPI:
Office Contact:		Practice Name / Collaborating Physician:		
Address:		City:		
State:	Zip:	Phone:	Fax:	

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: ◯ M ◯ F	Weight:	Height:	Diabetic: ◯ Y ◯ N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? ◯ Y ◯ N		

Insurance Information

Primary Insurance:	Policy ID:	Group #:	
Policyholder Name:	Policyholder DOB:	BIN:	PCN:

Clinical Information | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

Diagnosis:	ICD-10:	Patient's Previous Treatment:			
Urine Drug Screen Attached: ◯Y ◯N	Date of Diagnosis: / /	Transplant: ◯Y ◯N	Transplant Type:		
Biopsy: ◯Y ◯N	Fibrosis:	Scale (0-4):	Genotype:	Initial Viral Load: IU/ml	Date: / /	HIV: ◯Y ◯N
Hepatitis B Testing Completed: ◯Y ◯ N	Date Taken: / /	Result: ◯ Positive ◯ Negative			
RAV Testing Completed: ◯Y ◯ N	Date Taken: / /	Resistance Variants found:			
TREATMENT ARRANGEMENTS:	Start Date: / /	**Length of Therapy: ◯8 weeks ◯12 weeks ◯Other**			

Prescription Information

Medication	Dose/Strength	Sig	Quantity	Refills
◯ **VEMLIDY®**	◯25mg tablet	◯ Take 1 tablet by mouth once daily with food	30 Day Supply	
◯ **VOSEVI™**	◯400mg/100mg/100mg tablet	◯ Take 1 tablet by mouth daily with food	28 Day Supply	
◯ **XIFAXAN®**	◯550mg tablet	◯ Take 1 tablet by mouth 2 times a day	30 Day Supply	
◯ **ZEPATIER™**	◯50mg / 100mg tablet	◯ Take 1 tablet by mouth once daily with or without food	28 Day Supply	
◯ Other:				
◯ Other:				

By signing this form and utilizing our services, you are authorizing Meijer and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature:	**Date**	Prescriber Signature:	**Date**

Substitution Permitted

Dispense as Written

If brand is required, please write "DAW" in the box to the right.

MSP-Central-Hepatitis-092820