

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

Prescriber Information

Prescriber Name:		<input type="radio"/> MD <input type="radio"/> DO <input type="radio"/> NP <input type="radio"/> 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: <input type="radio"/> M <input type="radio"/> F	Weight:	Height:	Diabetic: <input type="radio"/> Y <input type="radio"/> N
Address:		City:	State:	Zip:	Allergies:	
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? <input type="radio"/> Y <input type="radio"/> 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: <input type="radio"/> Y <input type="radio"/> N	Date of Diagnosis: / /	Transplant: <input type="radio"/> Y <input type="radio"/> N	Transplant Type:			
Biopsy: <input type="radio"/> Y <input type="radio"/> N	Fibrosis:	Scale (0-4):	Genotype:	Initial Viral Load: IU/ml	Date: / /	HIV: <input type="radio"/> Y <input type="radio"/> N
Hepatitis B Testing Completed: <input type="radio"/> Y <input type="radio"/> N	Date Taken: / /	Result: <input type="radio"/> Positive <input type="radio"/> Negative				
RAV Testing Completed: <input type="radio"/> Y <input type="radio"/> N	Date Taken: / /	Resistance Variants found:				
TREATMENT ARRANGEMENTS:	Start Date: / /	Length of Therapy: <input type="radio"/> 8 weeks <input type="radio"/> 12 weeks <input type="radio"/> Other				

Prescription Information

Medication	Dose/Strength	Sig	Quantity	Refills
<input type="radio"/> EPCLUSA® <input type="radio"/> SOFOSBUVIR/VELPATASVIR	<input type="radio"/> 400mg / 100mg tablet	<input type="radio"/> Take 1 tablet by mouth once daily with or without food	28 Day Supply	
<input type="radio"/> HARVONI™ <input type="radio"/> LEDIPASVIR/SOFOSBUVIR <small>*generic only available in 90mg/400mg formulation</small>	<input type="radio"/> 90mg / 400mg tablet <input type="radio"/> 45mg / 200mg tablet <input type="radio"/> 45mg / 200mg pellets <input type="radio"/> 33.75mg / 150mg pellets	Adults <input type="radio"/> Take 1 tablet by mouth once daily with or without food Pediatrics Age 3 and Older: Weight ≥ 35kg: <input type="radio"/> Take one 90mg/400mg tablet by mouth once daily <input type="radio"/> Take two 45mg/200mg tablets by mouth once daily <input type="radio"/> Take two 45mg/200mg packets of pellets by mouth once daily Weight 17-34kg: <input type="radio"/> Take one 45mg/200mg tablet or packet of pellets by mouth once daily Weight <17kg: <input type="radio"/> Take one 33.75mg/150mg packet of pellets by mouth once daily	28 Day Supply	
<input type="radio"/> MAVYRET™	<input type="radio"/> 100mg / 40mg tablet	<input type="radio"/> Take 3 tablets by mouth once daily with food	28 Day Supply	
<input type="radio"/> RIBAVIRIN	<input type="radio"/> 200mg tablet <input type="radio"/> 200mg capsule	<input type="radio"/> _____ taken with food	28 Day Supply	
<input type="radio"/> SOVALDI™	<input type="radio"/> 400mg tablet <input type="radio"/> 200mg tablet <input type="radio"/> 200mg pellets <input type="radio"/> 150mg pellets	Adults: <input type="radio"/> Take 1 tablet (400mg) by mouth once daily with or without food Pediatrics Age 3 and Older: Weight ≥ 35kg: <input type="radio"/> Take one 400mg tablet by mouth once daily <input type="radio"/> Take two 200mg tablets by mouth once daily <input type="radio"/> Take two 200mg packets of pellets by mouth once daily Weight 17-34kg: <input type="radio"/> Take one 200mg tablet by mouth once daily <input type="radio"/> Take one 200mg packet of pellets by mouth once daily Weight <17kg: <input type="radio"/> Take one 150mg packet of pellets by mouth once daily	28 Day Supply	

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
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Substitution Permitted

Dispense as Written

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