



SPECIALTY PHARMACY

HEPATOLOGY

New Orleans, LA toll free 888.355.4191 toll free fax 888.355.4192

krogerspecialtypharmacy.com

DATE: _____ NEEDS BY DATE: _____ SHIP TO: PATIENT OFFICE OTHER _____

PATIENT INFORMATION	
Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female

PRESCRIBER INFORMATION		
Prescriber Name		
DEA #	NPI #	License #
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

PLEASE FAX COPY OF: PRESCRIPTION CARD FRONT & BACK CLINICAL NOTES MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Chronic Hepatitis C: B18.2 Hepatic Encephalopathy: K72.90 K72.91 Hepatocellular Carcinoma: C22.0 C22.2 C22.7 C22.8
 Other: _____
 Drug Allergies: _____ Weight: _____ kg lb
 Genotype: 1 1a (NS5A RAVs: ___ Yes ___ No) 1b 2 3 4 5 6 Viral Load: _____ IU/ml Viral Load Date: _____
 Treatment Naive Previously Treated: Prior treatment used: _____ Non-Responder Responder/Relapser
 Duration of Previous Therapy: From _____ To _____ Total of: _____ months
 HIV Coinfected: Yes No HBV Coinfected: Yes No Solid Organ Transplant Recipient: Yes No Awaiting Liver Transplant? Yes No METAVIR Score: _____
 Cirrhosis: Yes No - If Cirrhotic, is patient Compensated OR Decompensated; MUST provide: albumin _____ g/dL, total bilirubin _____ mg/dL, and INR _____

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
<input type="checkbox"/> Doptelet®	20mg Tablet	<input type="checkbox"/> Take 2 tablets (40mg total) by mouth daily for 5 days <input type="checkbox"/> Take 3 tablets (60mg total) by mouth daily for 5 days *DOPTELET® should be initiated 10 to 13 days prior to scheduled procedure date	10 15	_____ _____
<input type="checkbox"/> Epclusa®	sofosbuvir and velpatasvir 400mg/100mg Tablet	Take 1 tablet by mouth daily with or without food	28 Day Supply	_____
<input type="checkbox"/> Harvoni®	ledipasvir and sofosbuvir 90mg/400mg Tablet	Take 1 tablet by mouth daily with or without food	28 Day Supply	_____
<input type="checkbox"/> Mavyret®	glecaprevir/pibrentasvir 100mg/40mg Tablet	Take 3 tablets by mouth once daily with food	28 Day Supply	_____
<input type="checkbox"/> Olysio®	150mg Capsule	Take 1 capsule by mouth daily with food	28 Day Supply	_____
<input type="checkbox"/> Sovaldi®	400mg Tablet	Take 1 tablet by mouth daily with or without food	28 Day Supply	_____
<input type="checkbox"/> Vosevi™	sofosbuvir, velpatasvir, voxilaprevir 400mg/100mg/100mg Tablet	Take 1 tablet by mouth daily with food	28 Day Supply	_____
<input type="checkbox"/> Zepatier™	elbasvir/grazoprevir 50mg/100mg Tablet	Take 1 tablet by mouth daily with or without food	28 Day Supply	_____
<input type="checkbox"/> Moderiba <input type="checkbox"/> Ribavirin <input type="checkbox"/> Ribasphere®	200mg Tablet 200mg <input type="checkbox"/> Tablet <input type="checkbox"/> Capsule 200mg <input type="checkbox"/> Tablet <input type="checkbox"/> Capsule	<input type="checkbox"/> 600mg AM and 600mg PM (1200mg) <input type="checkbox"/> 600mg AM and 400mg PM (1000mg) <input type="checkbox"/> 400mg AM and 400mg PM (800mg) <input type="checkbox"/> 400mg AM and 200mg PM (600mg) <input type="checkbox"/> Other: Take _____ mg AM and _____ mg PM	28 Day Supply	_____
<input type="checkbox"/> Xifaxan	550mg Tablet	Take 1 tablet by mouth twice daily Indicate previously failed therapy: <input type="checkbox"/> Lactulose <input type="checkbox"/> Other _____	30 Day Supply	_____
<input type="checkbox"/> Other				

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

Prescriber's Signature (no stamps) Substitution Permitted Date Prescriber's Signature (no stamps) Dispense As Written Date

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