Hepatitis C Enrollment Form



Fax Referral To: 1-877-552-2907 Email Referral To: Customer.ServiceFax@CVSHealth.com

Phone: 1-888-345-1678

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The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

Hepatitis C Enrollment Form
Please Complete Patient and Prescriber Information

atient Name:	Patient D0	Patient DOB: Patient Phone:		
rescriber Name:		Pr	rescriber Phone:	
PRESCRIPTION INI	FORMATION			
MEDICATION	STRENGTH		DOSE & DIRECTIONS	QUANTITY/REFILLS
Mavyret Tablet (glecaprevir and pibrentasvir)	Fixed-dose combination tablet of 100 mg glecaprevir and 40 mg pibrentasvir	Take t	three tablets PO once a day with food.	Quantity: 28-day supply Refills: 8 weeks 12 weeks Other
Mavyret Oral Pellets (glecaprevir and pibrentasvir)	Unit-dose pellet packets of 50 mg glecaprevir and 20 mg pibrentasvir	kg / lb (please circle) Mix packet(s) of oral pellets with a small amount of soft food and swallow once daily Other:		Quantity: 28-day supply Refills: 8 weeks 12 weeks Other
Ribavirin	200 mg tablets 200 mg capsules	Take tabs/caps PO q am and tabs/caps q pm for a total of mg daily with food.		Quantity: Refills:
Sovaldi (sofosbuvir)	400 mg tablets	Take one 400 mg tablet PO once a day.		Quantity: 28-day supply Refills:
Vosevi sofosbuvir, velpatasvir, and voxilaprevir)	Fixed-dose combination tablet of 400 mg sofosbuvir / 100 mg velpatasvir/100 mg voxilaprevir	Take one tablet PO once a day with food.		Quantity: 28-day supply Refills: 12 weeks Other
Zepatier [elbasvir and grazoprevir]	Zepatier (elbasvir/grazoprevir)	Take one tablet once daily with or without food.		Quantity: 28-day supply Refills: 12 weeks 16 weeks
	. •	ED (ST	Ancillary supplies and kits FAMP SIGNATURE NOT ALLO May Substitute / Product Selection Permitted /	provided as needed for administratio
DAW / May Not Substitute	Date:		Substitution Permissible Prescriber's Signature:	Date:

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and sub mit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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