

Deliver to: Patient's Home Prescriber's Office Other: _____ Hold shipment until notified by prescriber Anticipated Start Date: _____

1. Patient Information

Last Name: _____ First Name: _____ Home Phone: _____ Work/Mobile Phone: _____
 S.S. #: _____ Date of Birth: _____ Home Address: _____
 Guardian/Caregiver: _____ City: _____ State: _____ Zip: _____
 Patient Preferred Language: _____ Sex: Male Female Height: _____ Weight: _____ lbs. kg.

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription & medical)

Medical Insurance: _____ Phone: _____ Prescription Card: _____ Phone: _____
 Subscriber Name: _____ Policy #: _____ BIN/PCN: _____
 Policy #: _____ Group #: _____ Medicare #: _____ Medicaid #: _____

3. Prescriber Information

Prescriber Name: _____ MD DO NP PA License #: _____ NPI #: _____ DEA #: _____
 Practice Name: _____ Phone: _____ Fax: _____
 Address: _____ Office Contact: _____ Phone: _____
 City: _____ State: _____ Zip: _____ Collaborating Physician: _____

4. Diagnosis & Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Primary ICD-10: _____ Concurrent Medications: _____
 Secondary ICD-10: _____
 Allergies: _____ Meds Tried & Failed: _____
 History of Liver Biopsy? YES NO
 Degree of Fibrosis: _____ Fibroscan (0-75): _____ Fibrotest (0.00-1.00): _____
 Genotype: _____ Viral Load: _____ Viral Load Date: _____
 ALT: _____ AST: _____ Hgb: _____ Plt: _____
 Serum Creatine (SCr): _____ Date of last lab draw: _____
 Other Disease States: _____
 Cirrhosis: None Compensated De-compensated
 Transplant status: Pre-transplant Post-transplant N/A
 HIV co-infection: Yes No HBV co-infection/history: Yes No
 Duration of Treatment: From _____ to _____. Total of _____ wks
 Treatment Naïve Partial Responder Previous Treatment
 Partial Responder/Relapser Non-responder Other _____
 Serum Creatine (SCr): _____ Date of last lab draw: _____
 ALT: _____ AST: _____ Hgb: _____ Plt: _____

5. Prescription Information

Harvoni:	Ledipasvir/ sofosbuvir, 90/400mg tabs	Take one-tab daily PO with or without food	QTY: 28, refills _____
Sovaldi:	Sofosbuvir 400mg tabs	Take one-tab daily PO with or without food	QTY: 28, refills _____
Veikira XR:	Dasabuvir, ombitasvir, paritaprevir, ritonavir: 200/8.33/50/33.33 mg	Take 3 tabs daily PO with a meal	QTY: 28 day supply, refills _____
Ribavirin:	200mg tab	Take ___mg PO am and ___ mg PO pm	QTY: 28 day supply, refills _____

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

Account Manager

Patient Signature _____ Date ____ / ____ / ____

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize KnippeRx, Inc. to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible _____ **PREScriBER SIGNATURE REQUIRED. NO STAMPS.** Date ____ / ____ / ____

Prescriber Signature-Dispense as Written _____ **PREScriBER SIGNATURE REQUIRED. NO STAMPS.** Date ____ / ____ / ____