Faxed prescriptions will only be accepted from a prescriber. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Senderra.

SENDERRA
Specialty Pharmacy
1301 E. Arapaho Rd., Ste. 101
Richardson, TX 75081
This prescription form is to be sent & received via fax

Hepatitis C Enrollment Form

Physician Offices Call: 855-460-7928

Fax: 888-777-5645

Prescriber:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Phone:	Fax:
Contact:	

PATIENT INFORMATION

Name:	☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other	DOB: ____/____/_____	SS#: ____-____-_____
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	☐ English ☐ Spanish ☐ Other: _____	Wt.: Ht.:

PRESCRIPTION

☐ **New** ☐ **Refill** **Ship by:** ____/____/_____ **Ship to:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other:** _____

Drug	Strength	Directions & Quantity	Refills
Epclusa® (*sofosbuvir/velpatasvir*)	☐ 400/100 mg Tablet	☐ Take one tablet PO QD with or without food (Quantity: 28)	
	☐ 400/100 mg Tablet ☐ 200/50 mg Tablet	**PEDIATRIC:** ***WEIGHT REQUIRED**** _____ ☐ Take one tablet PO QD with or without food (Quantity: 28) ☐ Take two tablets PO QD with or without food (Quantity: 56) ***Intended for weight ≥ 30 kg/66 lbs	
	☐ 200/50 mg Tablet	☐ Take one tablet PO QD with or without food (Quantity: 28) ***Intended for weight 17 kg/37 lbs to < 30 kg/66 lbs***	
Harvoni® (*ledipasvir/sofosbuvir*)	☐ 90/400 mg Tablet	☐ Take one tablet PO QD with or without food (Quantity: 28)	
	☐ 90/400 mg Tablet ☐ 45/200 mg Tablet ☐ 45/200 mg Pellets	**PEDIATRIC:** ***WEIGHT REQUIRED**** _____ ☐ Take one tablet PO QD with or without food (Quantity: 28) ☐ Take two tablets PO QD with or without food (Quantity: 56) ***Intended for weight ≥ 35 kg/77 lbs*** ☐ Take two packets of pellets QD with or without food (Quantity: 56)	
	☐ 45/200 mg Tablet ☐ 45/200 mg Pellets	☐ Take one tablet PO QD with or without food (Quantity: 28) ☐ Take one packet of pellets PO QD with or without food (Quantity: 28) ***Intended for weight 17 kg/37 lbs to < 35 kg/77 lbs***	
	☐ 33.75/150 mg Pellets	☐ Take one packet of pellets PO QD with or without food (Quantity: 28) ***Intended for weight < 17 kg/37 lbs***	
Mavyret™	☐ 100/40 mg Tablet	☐ Take three tablets PO QD with food (Quantity: 84)	
Sovaldi®	☐ 400 mg Tablet	☐ Take one tablet PO QD with or without food (Quantity: 28)	
	☐ 400 mg Tablet ☐ 200 mg Tablet ☐ 200 mg Pellets	**PEDIATRIC:** ***WEIGHT REQUIRED**** _____ ☐ Take one tablet PO QD with or without food (Quantity: 28) ☐ Take two tablets PO QD with or without food (Quantity: 56) ***Intended for weight ≥ 35 kg/77 lbs*** ☐ Take two packets of pellets QD with or without food (Quantity: 56)	
	☐ 200 mg Tablet ☐ 200 mg Pellets	☐ Take one tablet PO QD with or without food (Quantity: 28) ☐ Take one packet of pellets PO QD with or without food (Quantity: 28) ***Intended for weight 17 kg/37 lbs to < 35 kg/77 lbs***	
	☐ 150 mg Pellets	☐ Take one packet of pellets PO QD with or without food (Quantity: 28) ***Intended for weight < 17 kg/37 lbs***	
Viekira Pak®	☐ 12.5/75/50 mg Tablet	☐ Take two pink tablets PO QD (morning) and one beige tablet PO BID (morning and evening) with a meal (Quantity: 56/56)	
Vosevi®	☐ 400/100/100 mg Tablet	☐ Take one tablet PO QD with food (Quantity: 28)	
Zepatier®	☐ 50/100 mg Tablet	☐ Take one tablet PO QD with or without food (Quantity: 28)	

RIBAVIRIN PRODUCTS

Directions & Quantity			
☐ Take 400 mg QAM, 600 mg QPM (Quantity: 140) ☐ Take 600 mg QAM, 600 mg QPM (Quantity: 168) ☐ Take____mg QAM, ____mg QPM (Quantity: ____)	☐ **Copegus® Tablet** ☐ **Ribavrin Tablet**	☐ **Moderiba™ Tablet** ☐ **Ribavrin Capsule**	☐ **Ribasphere® RibaPak®** ☐ **Moderiba™ Dose Pack**

MEDICAL INFORMATION

PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES & LAB WORK REGARDING THERAPY

Diagnosis: ☐ B18.2 Chronic Hepatitis C Virus (HCV) Date of Diagnosis: ___/___/_____	**Treatment Naïve?** ☐ Yes ☐ No
Genotype: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 **Subtype:** ☐ A ☐ B ☐ A/B ☐ N/A	**Baseline viral load:** _____**IU/mL Date:** ___/___/_____
Cirrhosis: ☐ Yes ☐ No (if yes, is it: ☐ compensated ☐ decompensated)	**Co-infection status:** ☐ HIV ☐ HBV ☐ N/A
Degree of liver fibrosis: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4	**Polymorphism(s):** ☐ NS5A ☐ IL28B ☐ Q80K ☐ N/A

Prior HCV Treatment:	Date(s) of treatment:	Treatment weeks:	Treatment Response:
			☐ Incomplete ☐ Null ☐ Partial ☐ Relapsed

Allergies: _____ **Expected Duration of Therapy:** ☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ 24 weeks

Additional Clinical Information:

PRESCRIBER SIGNATURE REQUIRED---STAMPED SIGNATURE NOT ALLOWED

To Prescriber: By signing this form and utilizing our services, you are also authorizing Senderra to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

PRODUCT SUBSTITUTION PERMITTED	DISPENSE AS WRITTEN
X _____ Date: ____/____/_____	X _____ Date: ____/____/_____

CONFIDENTIALITY NOTICE