Faxed prescriptions will only be accepted from a prescribing practitioner. 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

Prescribing Practitioner:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Office:	Fax:
Contact:	

PATIENT INFORMATION

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

PRESCRIPTION

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

Drug	Strength	Directions & Quantity	Refills
Daklinza®	☐60 mg Tablet ☐30 mg Tablet* ☐90 mg Tablet*	Take 1 tablet PO QD with or without food (Quantity: 28) **30 mg dose is intended for use with strong CYP3A inhibitors* **90 mg dose is intended for use with moderate CYP3A inducers**	
Epclusa®	☐400/100 mg Tablet *(sofosbuvir/velpatasvir)*	Take 1 tablet PO QD with or without food (Quantity: 28)	
Harvoni®	☐400/90 mg Tablet *(sofosbuvir/ledipasvir)*	Take 1 tablet PO QD with or without food (Quantity: 28)	
Mavyret™	☐100/40 mg Tablet *(glecaprevir/pibrentasvir)*	Take 3 tablets PO QD with food (Quantity: 84)	
Sovaldi®	☐400 mg Tablet *(sofosbuvir)*	Take 1 tablet PO QD with or without food (Quantity: 28)	
Viekira Pak®	☐12.5/75/50 mg Tablet *(ombitasvir/paritaprevir/ritonavir/dasabuvir)*	Take 2 pink tablets PO QD (morning) and 1 beige tablet PO BID (morning and evening) with a meal (Quantity: 56/56)	
Vosevi®	☐400/100/100 mg Tablet *(sofosbuvir/velpatasvir/voxilaprevir)*	Take 1 tablet PO QD with food (Quantity: 28)	
Zepatier®	☐50/100 mg Tablet *(elbasvir/grazoprevir)*	Take 1 tablet PO QD with or without food (Quantity: 28)	

RIBAVIRIN PRODUCTS

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

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
_____	_____	_____	☐Incomplete ☐Null ☐Partial ☐Relapsed

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

Additional Clinical Information:

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: 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.

Prescribing Practitioner: | **Date**: _____/_____/_____

CONFIDENTIALITY NOTICE

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