



# HEPATITIS C

E-SCRIBE and FAX ENROLLMENT FORM

**NOBLE NORTHEAST:** E-Scribe: NOBLE | Fax: 888-842-3977 | Tel: 888-843-2040

**NOBLE SOUTHEAST:** E-Scribe: NOBLEMS/TRANSCRIPT | Fax: 601-420-4040 | Tel: 866-420-4041

Delivery Needed By: \_\_\_\_\_ Deliver to:  Patient's Home  Physician's Office  Other: \_\_\_\_\_

| PATIENT INFORMATION                                   | PROVIDER INFORMATION                     |
|---|--|
| Patient Name: _____ <input type="checkbox"/> Male     | Prescriber's Name: _____                 |
| Street Address: _____ <input type="checkbox"/> Female | Office Contact Name: _____               |
| City: _____ State: _____ Zip Code: _____              | Address: _____                           |
| Phone Number: _____                                   | City: _____ State: _____ Zip Code: _____ |
| Email Address: _____                                  | Phone Number: _____ Fax Number: _____    |
| Last Four of Social: _____ Date of Birth: _____       | DEA/NPI#: _____                          |

## INSURANCE - PLEASE FAX A COPY OF PRESCRIPTION CARD FRONT & BACK

### CLINICAL INFORMATION

Diagnosis: \_\_\_\_\_ Has the patient been treated previously for this condition?  Yes  No

ICD-10 Code: \_\_\_\_\_ Cirrhosis:  Yes  No

Height: \_\_\_\_\_ ft \_\_\_\_\_ ins Weight: \_\_\_\_\_ lbs If yes, decompensated?  Yes  No

Viral Load: \_\_\_\_\_ Genotype: \_\_\_\_\_ Medications Failed: \_\_\_\_\_

Metavir Fibrosis Score: \_\_\_\_\_ Medications On: \_\_\_\_\_

Allergies: \_\_\_\_\_

Other Notes: \_\_\_\_\_

### PRESCRIPTION INFORMATION

| Medication:                                 | Dosage/Strength:   | Directions:   | Quantity:                              | Refills: |
|---|--|---|--|----------|
| Daklinza                                    | <input type="checkbox"/> 30mg tablet<br><input type="checkbox"/> 60mg tablet<br><input type="checkbox"/> 90mg tablet   | <input type="checkbox"/> Take one tablet by mouth once daily  | <input type="checkbox"/> 4-week supply |          |
| Epclusa*                                    | <input type="checkbox"/> 400-100mg tablet  | <input type="checkbox"/> Take one tablet by mouth once daily  | <input type="checkbox"/> 4-week supply |          |
| Epclusa generic:<br>Sofosbuvir; Velpatasvir | <input type="checkbox"/> 400-100mg tablet  | <input type="checkbox"/> Take one tablet by mouth once daily  | <input type="checkbox"/> 4-week supply |          |
| Harvoni*                                    | <input type="checkbox"/> 90-400mg tablet   | <input type="checkbox"/> Take one tablet by mouth once daily  | <input type="checkbox"/> 4-week supply |          |
| Harvoni generic:<br>Ledipasvir; Sofosbuvir  | <input type="checkbox"/> 90-400mg tablet   | <input type="checkbox"/> Take one tablet by mouth once daily  | <input type="checkbox"/> 4-week supply |          |
| Mavyret*                                    | <input type="checkbox"/> 100/40mg tablet   | <input type="checkbox"/> Take 3 tablets by mouth one time daily with food   | <input type="checkbox"/> 4-week supply |          |
| Pegasys*                                    | <input type="checkbox"/> 180mcg/ml single-dose vial<br><input type="checkbox"/> 180mcg/0.5ml prefilled syringe<br><input type="checkbox"/> 180mcg/0.5ml autoinjector | <input type="checkbox"/> Inject 180mcg SC once weekly   |  |          |
| Ribavirin*                                  | <input type="checkbox"/> 200mg tablet<br><input type="checkbox"/> 200mg capsule  | <input type="checkbox"/> Take _____ tablet(s) by mouth _____ time(s) daily<br><input type="checkbox"/> Take _____ capsule(s) by mouth _____ time(s) daily | <input type="checkbox"/> 4-week supply |          |
| Solvaldi*                                   | <input type="checkbox"/> 400 mg tablet   | <input type="checkbox"/> Take one tablet by mouth once daily  | <input type="checkbox"/> 4-week supply |          |
| Vosevi*                                     | <input type="checkbox"/> 400/100/100mg tablet  | <input type="checkbox"/> Take one tablet by mouth once a day with food  | <input type="checkbox"/> 4-week supply |          |
| Zepatier*                                   | <input type="checkbox"/> 50/100mg tablet   | <input type="checkbox"/> Take one tablet by mouth once a day with food  | <input type="checkbox"/> 4-week supply |          |
| Other                                       |  |   |  |          |

Patient is interested in patient support programs

Ancillary supplies provided for administration

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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