Mast Specialty Pharmacy Hepatitis C Enrollment Form

PATIENT INFORMATION

Patient Name:____________________
Address:____________________
City,St,Zip____________________
Phone (H) __________ Phone (other)__________
Date of Birth __________ Gender __________
Primary Language__________

PRESCRIBER INFORMATION

Prescriber's Name____________________
DEA#__________ NPI#__________
Group/Hosp ____________________
Address:____________________
City,St,Zip____________________
Phone:__________Fax__________
Contact Person:____________________
Phone: __________

INSURANCE INFORMATION

Carrier Name	BIN#	PCN#	GRP#	ID#	Insured Name

STATEMENT OF MEDICAL NECESSITY

Diagnosis: ___070.54 Chronic Hepatitis C ___070.51 Acute Hepatitis C ___050.5 Liver Transplant ___ 042 HIV ___Other
Date of Diagnosis __________

Patient Evaluation:
HCV Genotype ___ 1a ___1b ___ 1 ___2 ___3 ___4 ___5 ___6 Weight______ Allergies:__________
Is patient: ___ Naïve ___ Partial Responder ___ Non-Responder ___ Relapser Last Date of Therapy __________
Product Names__________
Is patient currently on Hepatitis C Virus (HCV) therapy? Y N If yes, Therapy Start Date __________
Product Names__________
What is the viral load at 4 wks __________ IU/ml 8 wks __________ IU/ml 12 wks __________ IU/ml 24 wks __________ IU/m
Will the viral load be assessed at 4, 8, 12, 24 weeks? Y N Initial HCV RNA (Baseline) __________ IU/ml Date of Lab__________
Requested start date for Hepatitis C therapy __________ Actual start date for Hepatitis C therapy __________
Does the patient have any of the following?
___Autoimmune Hepatitis ___Decompensated Liver Disease ___Uncontrolled major depression or severe mental illness
___ Renal insufficiency with CrCl is < 50 ___ Poorly controlled or deteriorating cardiac disease ___ Hemoglobin < 8.5 g/dl
___ Hemoglobinopathy (e.g.Thalassemia, Sickle Cell anemia) ___ None of the above
Description ____________________
If taking Ribavirin, is the patient (or patient's partner) pregnant or unwilling to use adequate contraception? Y N N/A
Has patient previously failed therapy with a treatment regimen that includes a protease inhibitor? Y N
Check accompanying medications:
___Adcirca ___ Revatio ___ Alfuzosin ___Atorvastatin ___ Carbamazepine ___ Drospirenone ___ Ergot derivatives ___ Lovastatin
___Midazolam ___Phenobarbital ___Phenytoin ___Pimozide ___Rifampin ___Simvastatin ___St John's wort ___ Triazolam
___None of the Above

Specialty Pharmacy to coordinate injection training necessary? If yes, agency of choice__________
Training not necessary. Date training occurred __________
Reason: ___ MD office trained patient ___ Patient already trained ___ Will use alternative trainer

PRESCRIPTION INFORMATION

DRUG	STRENGTH	DOSE	QTY	REFILLS	DIRECTIONS

____________________ ____________________
Product Substitution Permitted Date Dispense as Written Date

PATIENT AUTHORIZATION

I authorize Mast Drug Co to enroll me in the Specialty Pharmacy program corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to, injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health conditions and prescription(s) to: coordinate the delivery of products and services available through the Specialty Pharmacy program, de-identified data for market analysis and provide educational information regarding therapies. I understand I may revoke this authorization at anytime in writing by sending a letter to Mast Drug Co, 1910 Ross Mill Rd, Henderson, NC 27537. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy.

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Patient Signature Date