HEPATITIS C PRESCRIPTION CHECKLIST

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Information | Insurance: | | |
| Name | Pharmacy: | | |
| DOB | * Avella | * CVS | * Acaria |
| Phone# | * Accredo | * Express | * \_\_\_\_\_ |
| Address |  |  |  |
| Genotype | MEDS: | | |

TO DO

|  |  |  |
| --- | --- | --- |
|  | TIME FRAME | COMPLETED |
| CBC | 30 DAYS |  |
| CMP | 30 DAYS |  |
| URINE TOX W/ETOH | 30 DAYS |  |
| HCG QUAL (if childbearing) | 30 DAYS |  |
| GENO TYPE | 90 DAYS |  |
| VIRAL RNA | 90 DAYS |  |
| HIV | 1 YEAR |  |
| FIBROSURE/LIVER BX/FIBROSCAN | NOT SPECIFIED |  |
| HEP A IZ OR IMMUNITY | NOT SPECIFIED |  |
| HEP B IZ OR IMMUNITY | NOT SPECIFIED |  |
| COPY OF MARIJUANA CARD |  |  |
| Last Chart Note |  |  |
|  |  |  |

FORMS

|  |  |
| --- | --- |
| PHQ-9 |  |
| AUDIT-C |  |
| CONSENT FOR MEDS |  |
| AUTHORIZED REPRESENTATIVE |  |
| Rx PRIOR AUTH |  |
|  |  |
|  |  |

COMMENTS

|  |  |  |  |
| --- | --- | --- | --- |
| APPROVED | DENIED | DELIVERY DATE | START DATE |
| Notes: | | | |
|  | | | |
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