

MATRxVIP

MATRIX VIP PHARMACY

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Phone (866) 410-3306 Fax (866) 410-3304

Questions? E-mail us at INFO@MATRIX-PHARMACY.COM or Call (866) 410-3306. We are here to assist you!

HEPATITIS C ENROLLMENT FORM

PATIENT INFORMATION & DEMOGRAPHICS

ORDER DATE: _____ PLANNED START DATE (if known): _____

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ DOB: _____ Female Male

INSURANCE COMPANY: _____ ID#: _____

GROUP#: _____ EMERGENCY CONTACT: _____

PRESCRIPTION INFORMATION

DIAGNOSIS: B18.2 Chronic Viral Hepatitis C Other: _____

ALLERGIES: NKA

GENOTYPE: _____ VIRAL LOAD: _____ DATE: _____ TX HISTORY: _____

Drug	Directions	Quantity	
<input type="checkbox"/> Mavyret 100mg/40mg	Take 3 tablets by mouth once daily with food	28 Days Supply	

PRESCRIBER INFORMATION

OFFICE/CLINIC NAME: _____ ATN: _____

OFFICE ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

PRESCRIBER NAME _____

NPI: _____ LICENSE: _____ DEA: _____

PRESCRIBER SIGNATURE: _____ DATE: _____

(substitution permissible if applicable)

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE "BRAND NECESSARY" OR "BRAND MEDICALLY NECESSARY" IN THE SPACE BELOW.
