Hepatitis C Referral Form

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PATIENT INFORMATION

Patients Name :		SSN#:		DOB:	
Address:	City:	State:		Zip:	
Home Phone:	Cell Phone:	Height:	Weight:	Gender: Male Female	
Email Address:		Diagnosis Code:			

INSURANCE INFORMATION (or attach copy of your cards)

Primary Insurance Co:	RxBIN:	RxPCN:	RxGroup:	RxID:	Phone:
Secondary Insurance Co:	RxBIN:	RxPCN:	RxGroup:	RxID:	Phone:

PRESCRIPTION INFORMATION (For IV medications attach a copy of your prescription.)

HARVONI (ledipasvir 90mg/sofosbuvir 400mg)
❑ One tablet taken by mouth once daily.

Qty: 28 Day Supply Refills: ____

VIEKIRA PAK(ombitasvir/paritaprevir/ritonavir)
❑ Two ombitasvir/paritaprevir/ritonavir
12.5 mg/75 mg/50mg tablets once daily (in the morning)
and one dasabuvir 250mg tablet twice daily (morning and
evening) with meals

Qty: 28 Day Supply Refills: ____

SOVALDI (sofosbuvir)
❑ One 400mg tablet taken by mouth once daily.

Qty: 28 Day Supply Refills: ____

DAKLINZA (daclatasvir)
❑ 30mg ❑ 60mg
______ mg taken once daily with or without food.
*Combination with sofosbuvir

TECHNIVIE (ombitasvir, paritaprevir and ritonavir)
❑ Take (paritaprevir/ritonavir (150/100mg) with ombitasvir (25mg) once daily by mouth with a meal.
*Co-administered with Ribavirin

Qty: 28 Day Supply Refills: ____

OLYSIO (simeprevir)
❑ One 150mg tablet taken by mouth once daily

Qty: 28 Day Supply Refills: ____

❑ **RIBAPAK**
❑ **RIBAVIRIN** 200mg
❑ **MODERIBA**
______ mg AM ______ mg PM

Qty: ____ Refills: ____

PEGASYS (peginterferon alfa-2a)
❑ ProClick ❑ Pre-filled syringe
___________ mcg Sub Q weekly

Qty: ____ Refills: ____

CLINICAL INFO

HCV genotype:
❑ 1 ❑ 2 ❑ 3 ❑ 4
❑ 1a ❑ 2a ❑ 3a ❑ 4a
❑ 1b ❑ 2b ❑ 3b ❑ 4b
❑ Other ___________________
HCV RNA: _____________________
Cirrhosis: ❑ Y ❑ N
If YES: ❑ Compensated
❑ Decompensated

Comorbidities:
❑ HIV
❑ HBV
❑ Diabetes
❑ Other ______________**Fibrosis Stage:** ________**Child-Pugh Score:**__________

Responder status:
❑ Treatment Naïve ❑ Treatment Experienced
Prior Treatment:
Type: _________________________________

Duration:

From _________________**To** ______________**Total of** _______________**Wks**

Please use this section for additional directions or other medications not listed.

❑ OTHER :	
STRENGTH :	
SIG / DIRECTIONS	
QUANTITY :	REFILLS :

Prescriber Name:		Phone:	Fax:
Office Address:		Email:	NPI#:
DEA#:	LIC#:	❑ Dispense as written:	Date
Prescriber Signature :		Deliver To : ❑ M D Office	❑ Patient Home

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed Medications. We will also pursue available copay and financial assistance on behalf of your patients.