Hepatitis C R_X Referral Form

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Date Medication Needed: _____ **Ship To:** Patient's Home Prescriber's Office Pick-up (store location): _____ Injection training by pharmacy?

1: Patient Information

Patient Name: _____ **Birthdate:** _____ **Sex:** Male Female **Height:** _____ **Weight:** _____ lbs. kg.
Soc. Sec. #: _____ **Preferred Phone:** _____ **Known Allergies:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Alternate Caregiver Name: _____ **Preferred Phone:** _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

Provider Name: _____ **DEA#:** _____ **NPI#:** _____ **Tax ID#:** _____
Address: _____ **Phone:** _____ **Fax:** _____
City, State, Zip: _____ **Key Contact:** _____ **Phone:** _____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis/ICD-10: B 18.2 (Chronic hepatitis C virus) **Genotype:** 1 2 3 4 5 6 **Viral Load:** _____ **Date:** _____
Fibrosis Score: F0 F1 F2 F3 F4 **Subtype:** A B A/B N/A **Cirrhosis:** None Compensated Decompensated **Child-Pugh:** A B C
IL-28: CC CT TT **NS5A Polymorphism:** Y N **NS5A Polymorphism Type:** 28 30 31 93 Other_____ **HIV Co-infection** **HBV Co-infection**

Prior Therapy	End Date	Treatment Weeks	Response Status
			Naive Null Partial Relapse
			Naive Null Partial Relapse
			Naive Null Partial Relapse

4: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
Daklinza® (daclatasvir)	60mg 30mg	Take 1 tablet by mouth daily with or without food in combination with sofosbuvir	28 day supply	
Harvoni™ (ledipasvir/sofosbuvir)	90mg/400mg	Take 1 tablet by mouth daily with or without food	28 day supply	
Olysio™	150mg	Take 1 capsule by mouth daily with food *(Olysio is FDA approved for use with ribavirin and pegylated interferon, also approved in combination with Sovaldi)*	28 day supply	2
Pegasys® Prefilled Syringe Vial ProClick®	180mcg 135mcg	180 mcg SQ once weekly 90 mcg SQ once weekly 135 mcg SQ once weekly	28 day supply	
RibaPak® **Moderiba®**	600mg 800mg 1000mg 1200mg	200 mg Every Morning, 400 mg Every Evening 400 mg Every Morning, 400 mg Every Evening 600 mg Every Morning, 400 mg Every Evening 600 mg Every Morning, 600 mg Every Evening	28 day supply	
RibaSphere® (generic ribavirin)	200mg			
Sovaldi™	400mg	Take 1 tablet by mouth daily with or without food	28 day supply	
Technivie™ (ombitasvir, paritaprevir, and ritonavir tablets)	12.5mg/75mg/50mg	Take 2 ombitasivir, paritaprevir, ritonavir tablets by mouth once daily in the morning with a meal without regard to fat or calorie content *(Technivie is FDA approved for use with ribavirin)*	28 day supply	
Viekira Pak™ (ombitasvir, paritaprevir, and ritonavir tablets copackaged with dasabuvir tablets)	12.5mg/75mg/50mg/250mg	Take **2** ombitasvir, paritaprevir, ritonavir (pink tablets) once daily (in the morning) and **1** dasabuvir (beige tablet) twice daily (morning and evening) with a meal without regard to fat or calorie content	28 day supply	
Zepatier™ (elbasvir/grazoprevir)	50mg/100mg	Take 1 tablet by mouth daily with or without food	28 day supply	
Epclusa (sofosbuvir/velpatasvir)	400mg/100mg	1 Tab by mouth daily x 12weeks	28 day supply	2
Mavyret™ (glecaprevir + pibrentasvir)	100mg/40mg	Take 3 tablets by mouth once daily with food	28 day supply	
Vosevi™ (sofosbuvir/velpatasvir/voxilaprevir)	400mg/100mg/100mg	1 tablet by mouth once daily with food	28 day supply	

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: _____ Date: _____

Prescriber Signature: Prescriber, please sign and date below

Dispense as written _____ Date _____ Substitution Permissable _____ Date _____

Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions: _____

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