

Lifeline Specialty Pharmacy

# Hepatitis C Prescription Referral Form

3233 Corporate Ct.  
Ellicott City, MD 21043



Send your Rx to:

Fax Number: 410-203-1515  
Phone Number: 410-203-1010

Toll Free Number:  
1-833-4-LIFELINE

NPI: 1568975464

If you have questions or concerns, please contact us.

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: \_\_\_\_\_

## 2: Insurance Information

Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)  
 Primary Prescription Insurance \_\_\_\_\_ Rx Bin \_\_\_\_\_  
 Rx PCN \_\_\_\_\_ Patient ID/Policy Number \_\_\_\_\_ Patient Rx Group Number \_\_\_\_\_

## 3: Prescriber Information

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

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

Diagnosis/ICD-10: \_\_\_\_\_ Genotype: 1a 1b 2 3 4 5 6 Viral Load: \_\_\_\_\_ Date: \_\_\_\_\_  
 Fibrosis Score: F0 F1 F2 F3 F4 Cirrhosis:  None  Compensated  Decompensated  
 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
_____	_____	_____	<input type="checkbox"/> Naive <input type="checkbox"/> Null <input type="checkbox"/> Partial <input type="checkbox"/> Relapse
_____	_____	_____	<input type="checkbox"/> Naive <input type="checkbox"/> Null <input type="checkbox"/> Partial <input type="checkbox"/> Relapse

## 5: Prescription Information

Medication	Dose/Strength	Sig	Duration of Therapy
<input type="checkbox"/> Daklinza® (daclatasvir)	<input type="checkbox"/> 60mg <input type="checkbox"/> 30mg	Take 1 tablet by mouth daily, with or without food in combination with sofosbuvir	12 weeks 24 weeks
<input type="checkbox"/> Epclusa® (sofosbuvir/velpatasvir)	<input type="checkbox"/> 400mg/100mg	Take 1 tablet by mouth daily, with or without food	12 weeks 24 weeks
<input type="checkbox"/> Harvoni® (ledipasvir/sofosbuvir)	<input type="checkbox"/> 90mg/400mg	Take 1 tablet by mouth daily, with or without food	12 weeks 16 weeks 24 weeks
<input type="checkbox"/> Mavyret™ (glecaprevir/pibrentasvir)	<input type="checkbox"/> 100mg/40mg	Take three tablets once daily with food	8 weeks 16 weeks 12 weeks
<input type="checkbox"/> Pegasys® Prefilled Syringe <input type="checkbox"/> Vial ProClick®	<input type="checkbox"/> 180mcg <input type="checkbox"/> 135mcg	<input type="checkbox"/> 180 mcg SQ once weekly <input type="checkbox"/> 90 mcg SQ once weekly <input type="checkbox"/> 135 mcg SQ once weekly	24 weeks 48 weeks
<input type="checkbox"/> RibaPak® <input type="checkbox"/> Moderiba®	<input type="checkbox"/> 600mg <input type="checkbox"/> 800mg <input type="checkbox"/> 1000mg <input type="checkbox"/> 1200mg	Take _____ mg by mouth every morning and _____ mg by mouth every evening with food and plenty of water	24 weeks 48 weeks
<input type="checkbox"/> RibaSphere® (generic ribavirin)	<input type="checkbox"/> 200mg		24 weeks 48 weeks
<input type="checkbox"/> Sovaldi®	<input type="checkbox"/> 400mg	Take 1 tablet by mouth daily, with or without food	12 weeks 48 weeks 24 weeks
<input type="checkbox"/> Viekira Pak™ (ombitasvir, paritaprevir, ritonavir tablets copackaged with dasabuvir tablets)	2.5mg/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	12 weeks 24 weeks
<input type="checkbox"/> Viekira XR™ (coformulated tablet contains dasabuvir, ombitasvir, paritaprevir, and ritonavir)	200mg/8.33mg/ 50mg/33.33mg	Take 3 tablets, 1 pack, daily with a meal without regard to fat or calorie content	12 weeks
<input type="checkbox"/> Vosevi™ (sofosbuvir/velpatasvir/voxilaprevir)	<input type="checkbox"/> 400mg/100mg/100mg	Take 1 tablet by mouth daily with food	12 weeks
<input type="checkbox"/> Zepatier™ (elbasvir/grazoprevir)	<input type="checkbox"/> 50mg/100mg	Take 1 tablet by mouth daily, with or without food	12 weeks 16 weeks

**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 Permissible \_\_\_\_\_ Date \_\_\_\_\_

Authorize Lifeline Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.  
**IMPORTANT NOTICE:** This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. 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: \_\_\_\_\_