Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Lifeline Specialty **Pharmacy** 

## **Hepatitis C Prescription Referral Form**

6304 Woodside Ct, Ste 100 Columbia, MD 21046



Send your Rx to: Phone: 1-833-4-LIFELINE (1-833-454-3354) Fax: 1-833-785-4461

NPI: 1568975464

If you have questions or concerns, please contact us.

Soc. Sec. 7: Preferred Phone:	SPECIALITY PHARMACY								
Patient Name	Date Medication Needed:	Ship To:	] Patient's	Home Prescrib	er's Office	Pick-up (store locat	ion):		
Soc. Sc. F. Preferred Phone:	1: Patient Informat	ion							
Alternate Carcelover Name:    Pelease fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)   Primary Prescription Insurance   Patient ID/Policy Number   Patient Rx Group Number   Patient Rx Group Number   Patient Rx Group Number   Provider Name:   Provider Name:			Birthda	ate:	Sex	k: ☐ Male ☐ Female	Height:Weight:	lbs. [	kg.
Preferred Phone:   Prescription Information   Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)   Primary Prescription Insurance   Rx Bin   Rx PCN   Patient IDiPolicy Number   Patient Rx Group Number   Patient Rx Group Number   Provider Name:   DEA#:   NPH;   Tax IDIF-   Address:   Phone:   Fax:   Tax IDIF-   Tax	Soc. Sec. #:	Preferred Pho	ne:		Kn	own Allergies:			
Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical) Primary Prescription Insurance Rx PCNPatient ID/Policy NumberPatient Rx Group Number	Address:				City	y:	State:	Zip:	
Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)  Rx Bin   Rx	Alternate Caregiver Name:				Pre	ferred Phone:			
Primary Prescription Insurance Patient ID/Policy Number Patient ID/Policy Number Patient RX Group Number Patient RX Group Number    Patient RX Group Number   Fax:   Tax ID8:	2: Insurance Inforr	nation							
Petient ID/Policy Number		Please fax FRON	T and BA	CK copy of ALL	Insurance	cards (Prescription	and Medical)		
Provider Name:									
Provider Name:	Rx PCN	Patient ID/Pol	icy Numbe	;r		Patient Rx	Group Number		
Provider Name:	3: Prescriber Inform	mation							
Address:   Phone:   Fas:   Phone:   Pho					DE 4#.	ND	I#ı Tov ID#	·.	
St. Prescription Information   Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization   Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization   Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization   Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization   Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization   Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization   Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization   Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization   Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization   Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization   Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization   Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization   Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization   Please FAX recent clinical notes, and the prior the	·								
### A: Diagnosis/Clinical Information   Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization Diagnosis/ICD-10:									
Diagnosis/ICD-10:	<u> </u>	allaformation   B	loaso EAV	rocont clinical r	-		ascription to expedite the Pr	ior Authoriza	ation
Fibrosis Score: Fo Fot Fot Fot Fot Fot Fot Fot Fot Fot		-					-		lliOH
IL-28:   CC   CT   TNSSA Polymorphism:   Y   N NSSA Polymorphism Type:   28   30   31   93   Other   HIV Co-Infection   HEV Co-Infection   Prior Therapy   End Date   Treatment Weeks   Response Status   Navive   Null   Partial   Relapse							Date:		
Prior Therapy  End Date  Treatment Weeks  Response Status    Naive   Nutli   Partial   Relapse							r HIV Co-infection 🗆 I	HRV Co-infecti	ion 🗆
S: Prescription Information    Medication   Dose/Strength   Good   Dose/Strength   Gladialisative   Gladiali									оп <u>Г</u>
Signormation   Dose/Strength   Signormation   Dose/Strength   Gordan   Dose/Strength   Gordan   Dose/Strength   Gordan							□Naive □ Null □ Partial	Relapse	
Medication   Dose/Strength   Sig   Duration of There   Classification							□Naive □ Null □ Partial	Relapse	
Medication   Dose/Strength   Sig   Duration of There   Calcadistaswin   Gloring   Gloring   Take 1 tablet by mouth daily, with or without food in combination with sofosburir   12 weeks   24 weeks   Glocobunit/vepataswin   Gloring   Gl	<b>* TEXASIS</b>								
Daklinza*   Goomg   Calcitation*   Goomg   Calcitation*   Goomg   Calcitation*   Calcitation*   Calcitation*   Goomg   Calcitation*   Calci	•	n.	İ			-		Demetion of 3	Theres
Generic ribavirin	<u> </u>	_							ınerap
declarative plataswir   decl		<b>=</b> ~	Take 1 tal	blet by mouth dail	y, with or wi	ithout food in combin	ation with sofosbuvir		
Gedpestvir/solosabuvir)   190mg/400mg   Take 1 tablet by mouth daily, with or without food   24 weeks   16   12 weeks   16 weeks		☐400mg/100mg	Take 1 tablet by mouth daily, with or without food						
glecaprevir/pibrentasvir)   100mg/40mg   1ake three tablets once daily with food   12 weeks   Weeks   Preflided Syringe   Vial   135mcg   135mcg SQ once weekly   90 mcg SQ once weekly   24 weeks   48 weeks   RibaPake   Moderibae   600mg   1200mg   1200m		☐90mg/400mg	Take 1 tal	blet by mouth dail	y, with or wi	ithout food			16 weel
Prefiled Syringe   Vial   135mcg   135mcg   135mcg   135mcg   135mcg   135mcg SQ once weekly   190 mcg SQ once weekly   48 weeks   48 weeks   135mcg SQ once weekly   12 weeks   48 weeks		☐100mg/40mg	Take three	e tablets once dail	y with food				16 weel
RibaPake   Moderibae   600mg   800mg   1200mg					□90 m	24 weeks			
Received by the state of the					Ш				
RibaSphere®   200mg   1200mg   200mg   200mg   24 weeks   25 weeks   25 weeks   26 wee	☐ RibaPak® ☐ Moderiba®	□600mg □800mg	Take	mg by mouth $\epsilon$	every mornir	ng and mg by r	mouth every evening with food	24 weeks	
Generic ribavirin   Generic ribaviri ribalets   Generic ribavirin   Generic ribaviri ribalets   Generic ribaviri ribaviri ribalets   Generic ribaviri ribaviri ribalets   Generic ribaviri		1000mg 1200mg	and plent	ty of water					
Sovaldi®		□200mg							
Viekira Pak™ (ombitasvir, paritaprevir and ritonavir tablets copackaged with dasabuvir tablets)   2.5mg/75mg/ 50mg/250mg   2.5mg/75mg/ 50mg/250mg   50mg/33.33mg   50mg/33.3		□400mg	Take 1 tal	blet by mouth dail	v with or wi	ithout food			48
(ombitasvir, paritaprevir and ritonavir tablets copackaged with dasabuvir tablets)    Viekira XR™ (coformulated tablet contains dasabuvir, paritaprevir, and ritonavir)    Vosevi™ (sofosbuvir/velpatasvir/ voxilaprevir)    Zepatier™ (elbasvir/grazoprevir)    Zepatient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program attent Signature: Prescriber, please sign and date below    Zepatier Signature: Prescriber, please sign and date below   Date:   Dat		LI400IIIg	rano ra		,,			24 weeks	wee
ritionalvir tablets copackaged with dasabuvir tablets)    Viekira XR** (coformulated tablet contains dasabuvir, ombitasvir, paritaprevir, and ritionavir)    Vosevi** (sofosbuvir/velpatasvir/ voxilaprevir)    Zepatier** (elbasvir/grazoprevir)    Somg/100mg   Take 1 tablet by mouth daily, with or without food   12 weeks   16 weeks   17 weeks   17 weeks   18 weeks		2.5mg/75mg/				" ,	,	~ "	
Viekira XR™ (coformulated tablet contains dasabuvir, ombitasvir, paritaprevir, and rittonavir)       200mg/8.33mg/ 50mg/33.33mg       Take 3 tablets, 1 pack, daily with a meal without regard to fat or calorie content       12 weeks         □ Vosevi™ (sofosbuvir/velpatasvir/ voxilaprevir)       □ 400mg/100mg/100mg       Take 1 tablet by mouth daily with food       12 weeks         □ Zepatier™ (elbasvir/grazoprevir)       □ 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 attent Signature:         □ Date:		50mg/250mg		, ,	e daily (IIIO	offiling and evening) w	ili a meai willioul regalu to lat	24 weeks	
dasabuvir, ombitasvir, paritaprevir, and ritonavir)    Vosevi™ (sofosbuvir/velpatasvir/ voxilaprevir)   Zepatier™ (elbasvir/grazoprevir)   Date:    Prescriber Signature: Prescriber, please sign and date below    Take 1 tablet by mouth daily with food   12 weeks   12 weeks   16 weeks   17 weeks   18 weeks	Uiekira XR™	200ma/0.22ma/						40 1	
□Vosevi™ (sofosbuvir/velpatasvir/ voxilaprevir)       □400mg/100mg/100mg       Take 1 tablet by mouth daily with food       12 weeks         □Zepatier™ (elbasvir/grazoprevir)       □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 atient Signature:       Date:    Prescriber Signature: Prescriber, please sign and date below	dasabuvir,ombitasvir,		Take 3 tal	blets, 1 pack, daily	with a mea	al without regard to fat	t or calorie content	12 weeks	
(sofosbuvir/velpatasvir/voxilaprevir)								12 weeks	
Zepatier   Gelbasvir/grazoprevir   Date:   Take 1 tablet by mouth daily, with or without food   12 weeks 16 weeks   16	(sofosbuvir/velpatasvir/	400mg/100mg/100mg	Take 1 tal	blet by mouth dail	y with food			12 weeks	
Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program atient Signature:  Prescriber Signature: Prescriber, please sign and date below		D50	Take 4 to	blat by may the dail		ith out food		12 weeks	
atient Signature: Date:  Prescriber Signature: Prescriber, please sign and date below		Lisoring/Toomg	iake i (a)	olet by mouth dall	y, with Of Wi	iti lout loud		16 weeks	
atient Signature: Date:  Prescriber Signature: Prescriber, please sign and date below	Patient Support Programs:	Please sign and data	helow to	enroll in the ph	armacoutic	cal company assist	ed nationt cupport program		
Prescriber Signature: Prescriber, please sign and date below		i icase sigii aliu date	DEIOM (O	CITION III UIE PIIC	amaceulic	i i	ca palient support program		
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lauthorize 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: