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

LIFELINE SPECIALTY PHARMACY

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.

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
			☐Naive ☐Null ☐Partial ☐Relapse
			☐Naive ☐Null ☐Partial ☐Relapse

5: Prescription Information

Medication	Dose/Strength	Sig	Duration of Therapy
☐ **Daklinza®** (daclatasvir)	☐60mg ☐30mg	Take 1 tablet by mouth daily, with or without food in combination with sofosbuvir	☐12 weeks ☐24 weeks
☐ **Epclusa®** (sofosbuvir/velpatasvir)	☐400mg/100mg	Take 1 tablet by mouth daily, with or without food	☐12 weeks ☐24 weeks
☐ **Harvoni®** (ledipasvir/sofosbuvir)	☐90mg/400mg	Take 1 tablet by mouth daily, with or without food	☐12 weeks ☐16 weeks ☐24 weeks
☐ **Mavyret™** (glecaprevir/pibrentasvir)	☐100mg/40mg	Take three tablets once daily with food	☐8 weeks ☐16 weeks ☐12 weeks
☐ **Pegasys®** ☐Prefilled Syringe ☐Vial ☐ProClick®	☐180mcg ☐135mcg	☐180 mcg SQ once weekly ☐90 mcg SQ once weekly ☐135 mcg SQ once weekly	☐24 weeks ☐48 weeks
☐ **RibaPak®** ☐ **Moderiba®**	☐600mg ☐800mg ☐1000mg ☐1200mg	Take _____ mg by mouth every morning and _____ mg by mouth every evening with food and plenty of water	☐24 weeks ☐48 weeks
☐ **RibaSphere®** (generic ribavirin)	☐200mg		☐24 weeks ☐48 weeks
☐ **Sovaldi®**	☐400mg	Take 1 tablet by mouth daily, with or without food	☐12 weeks ☐48 weeks ☐24 weeks
☐ **Viekira Pak™** (ombitasvir, paritaprevir and 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
☐ **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
☐ **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

Patient Signature: Date:

Prescriber Signature: Prescriber, please sign and date below

Dispense as written Date Substitution Permissible Date

I authorize Lifeline Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

# of Prescriptions:_____