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

3233 Corporate Ct.
Ellicott City, MD 21042

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
			☐ 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 24 weeks 16 weeks
☐ **Mavyret™** (glecaprevir/pibrentasvir)	☐ 100mg/40mg	Take three tablets once daily with food	8 weeks 12 weeks 16 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 24 weeks 48 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 Permissable Date

I 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:________