HEPATITIS C PATIENT REFERRAL FORM

Therapy Start Date: ____/____/____ Ship To: ☐ Patient ☐ Physician 1st Fill ☐ Physician All Orders ☐ In-store Pickup

Patient Information: *Please attach FRONT and BACK copies of ALL insurance cards.*

Patient Name:_____ Date of Birth: ____/____/____ Sex: ☐Male ☐Female

Social Security #: _____ Primary Phone: (____) ____-_____ Secondary Phone: (____) ____-_____

Address: _____ City: _____ State: _____ Zip: _____

Physician Information:

Physician Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) ____-_____ Fax: (____) ____-_____ Key Contact: _____

Diagnostic Information: *Please attach recent Labs, Tests, and Clinical Notes.*

ICD-10: ☐B18.20 Hepatitis C(Chronic) ◆Genotype: ☐1a ☐1b ☐2 ☐3 ☐ 4 ☐ 5 ☐6 ◆Co-infected with HIV: ☐Yes ☐No

◆Treatment Experience: ☐Naïve ☐Non-Responder ☐Partial Responder ☐Relapser ◆Previous Treatment:_____

◆Viral Load:_____ Date:____/____/____ ◆History of liver biopsy: ☐Yes ☐No ◆Fibrosis Score: ☐F0 ☐F1 ☐F2 ☐F3 ☐ F4

◆Cirrhosis: ☐None ☐Compensated ☐De-compensated ◆Transplant Status: ☐Pre-transplant ☐Post-transplant ☐N/A

Prescription Information:

☐Harvoni® (ledipasvir/sofosbuvir) 90mg/400mg

Take 1 tablet PO once daily Supply: 1 mo Refill:_____

Harvoni Dosing Guidance: **(GENO 1, 4, 5&6)**

Tmt Experienced?	Cirrhosis?	Baseline Viral Load	Indicated Tmt Duration
No	No	<6million IU/mL	8 weeks_____
No	Yes or No	Detectable	12 weeks_____
Yes	No	Detectable	12 weeks_____
Yes	Yes	Detectable	24 weeks_____

☐RIBAPAK® ☐RIBAVIRIN 200mg

☐400mg PO QAM; 200mg PO QPM Supply: 1 mo Refill: _____

☐400mg PO QAM; 400mg PO QPM Supply: 1 mo Refill: _____

☐600mg PO QAM; 400mg PO QPM Supply: 1 mo Refill: _____

☐600mg PO QAM; 600mg PO QPM Supply: 1 mo Refill: _____

☐Other:___Supply: 1 mo Refill: _____

☐Vosevi™(sofosbuvir/velpatasvir/voxilaprevir) **(GENO 1,2,3,4,5&6)**

Take 1 tablet PO once daily with food Supply: 1 mo Refill:_____

☐Mavyret™ (glecaprevir/pibrentasvir) **(GENO 1,2,3,4,5&6)**

Take 1 dose pack PO daily with food Supply:1 mo Refill:_____

☐Epclusa® (sofosbuvir/velpatasvir) 400mg/100mg **(GENO 1-6)**

Take 1 tablet PO once daily Supply:1 mo Refill:_____

☐Zepatier™ (elbasvir/grazoprevir) 50mg/100mg **(GENO 1&4)**

Take 1 tablet PO once daily Supply:1 mo Refill:_____

Resistance Test? ☐Positive ☐Negative ☐N/A

☐Sovaldi® (sofosbuvir) 400mg

Take 1 tablet PO once daily Supply:1 mo Refill:_____

☐Daklinza™ (Daclatasvir) ☐30mg ☐60mg **(GENO 1, 2&3)**

Take 1 tablet PO once daily Supply:1 mo Refill:_____

☐Other: _____ SIG:_____ Supply:1 mo Refill:_____

Prescriber Prior Authorization Consent: Physician hereby authorizes the Pharmacy, as agent for Physician, to perform any of the following services on behalf of Physician for this Patient: To obtain prior authorization from applicable PBMs or other payors for drugs prescribed by Physician, including, as necessary, the provision of prerequisite clinical and other patient information; to conduct benefits investigations; and to conduct eligibility investigations. In furtherance of the Pharmacy providing the above services, Physician agrees to provide or make available to the Pharmacy from time to time such information regarding patient's treatment as might be requested by payor.

☐ **I certify that I am prescribing the drug(s) listed above. I authorize the Pharmacy to perform the above services on behalf of Physician for the benefit of the Patient.**

Physician's Signature: _____ ☐DAW (Dispense as Written) **Date** ____/____/____

Prescriber certifies that this referral form contains an original signature and is signed by the treating physician

Rep:_____ www.grubbsnw.com Rev.: 05/21/2018

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Phone: 202-503-2644 | Fax: 202-503-1721 GRUBB'S NW SPECIALTY PHARMACY 1517 17th Street NW, Washington DC 20036

Please provide the following information for prior authorization processing:

***All lab reports (or EMR) must be recent within the last 30 days.**

REQUIRED INFORMATION:

- Medication list and allergies
- Insurance information with RX insurance. Please include copy of card.
- Patient weight
- Genotype (hard copy from lab)
- HCV RNA (Viral load)
- Lab results with CBC, ALT/AST, HGB, INR, HFP AND GFR
- Liver biopsy/Metavir/FibroSure lab
- Previous medication treatments, dates and outcomes
- Drug / Alcohol test (if applicable)
  (Most plans are still requiring stage 2-4 fibrosis, but others simply need to see some form of testing)

- ***MD name/NPI/Office contact/Phone number***
- ***Drug indicated with refills and planned treatment duration***
- ***MD signature and date on referral form***

❖ ***Please forward to us any updates you receive from the insurance company regarding approvals or denials***

Our PA Team is here to help! Here is our contact information:
Main number: (202) 503-2644 | Fax number: (202) 503-1721

- To check the status of ***pending PA's***, or if you have any questions call **Dawn** at ext. 221 or **Nick** at ext. 218