## **HEPATITIS** REFERRAL FORM

Draw Date

Hgb .



PATIENT INFOR	RMATION			PRESCRIBE	R INFORMAT	ION			
Last Name	First Name		DOB	Name of Contact Sen	ding Referral		Title		
Gender	Last 4 SSN		Primary Language	Preferred Contact Method (check one)	□ Email □ Phone □ Fax	Referral Cont	tact Email		
Address				Office Phone		Office Fax	Office Fax		
City State			ZIP	Practice / Facility Nai	Practice / Facility Name				
Email				Address					
Home Phone	ome Phone Work Phone		Cell Phone	City		State	ZIP		
Primary Contact Method (check one)	☐ Cell Phone ☐ Text ☐ E ☐ DO NOT C	mail 🗆 Prim		Prescriber Name / Specialty					
Primary Caregiver/Alt Conta	act Name (If app	olicable)		Prescriber State Licer	Prescriber State License #				
Caregiver/Alt Contact Email Careg			giver/Alt Contact Phone	NPI#			Medicaid UPIN #		
INSURANCE IN	FORMATIO	ON							
Insurance Provider			Plan ID #	Eligible for Medicare (check one)					
BIN#: PCN#:			RX Group#:	Prescription Card (check one)					
Insured's Name			Relationship to Patient  Please include a copy of the front and back of ins						
CLINICAL INFO	RMATION	ı							
Is Patient (check all Partial Responder Non-Responder Non-Responder Last Date of Therapy Product Used Post Liver Transplant			Therapy Start Date  Anticipated Length	If Self-injectable drug coordination required Yes No	If Self-injectable drug, is injection training coordination required by our pharmacy?		Allergies □ NKDA □ Drug Allergies (please list)		
			of Therapy  8 weeks 12 weeks 16 weeks 24 weeks Other	Patient Height (cm/in	) Patient Weigl	ht (kg/lbs)	Date Obtained		
HCV Genotype □1a □1b □1 □1			sis sted Cirrhosis nsated Cirrhosis	Ship to Address	Ship to Address				
☐ Positive for Q80K Polymorphism Fi			ibrosis Score ] F0   F1   F2   F3   F4	ICD-10 Codes	□ B17.10 Acute HCV w/o Hepatic Coma □ B17.11 Acute HCV w/ Hepatic Coma □ B18.2 Chronic HCV □ B18.0 Chronic HBV with Delta-agent □ B18.1 Chronic HBV w/o Delta-agent				
Liver Biopsy  Yes No Date of liver biopsy Results of liver biopsy ANC  Praw D		IU/ml_	NA Viral Load f Labwork		□ B18.9 Chronic Viral Hepatitis □ B19.10 Unspecified HBV w/o Hepatic Coma □ B19.11 Unspecified HBV w/ Hepatic Coma □ B19.20 Unspecified HCV w/o Hepatic Coma □ B20 HIV				

We accept Escribe and fax prescriptions.

☐ K72.90 Hepatic Failure, Unspecified w/o Coma

☐ Other

## **PRESCRIPTIONS**

MAIN INFORMATION (MUST BE FILLED OUT TO PROCESS PAGES TOGETHER FOR OFFICIAL PATIENT RECORDS)														
Patient Last Name	Patient First N	Patient First Name DOB				Practice / Facility Name								
Address						Practice Address								
City State		State	ZIP			City		State	ZIP					
Date of Issue						NPI#		DEA#						
PRESCRIPTION INFORMATION														
In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.														
MEDICATION	DOSE			DIRECTIONS			QTY	REFILLS	DAW (Dispense as Written)					
					,	,			Total RXs					
Prescriber Signature  Supervising Physician Signatur	or Cultura			Date Date	_/	/								

\*\*The information contained in this document will become a legal prescription. Follow all state Medical Board guidelines when completing, inclusive of guidelines that pertain to the number of prescriptions allowed on a single prescription form. If more than one page is required, make additional copies. Use state board mandated language for dispensing brand name medications or generic substitution and follow physician signature requirements.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Healath Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material.