HEPATITIS C REFERRAL FORM (A-L)

PHONE 888.370.1724 | **FAX** 877.645.7514

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

PATIENT INFORMATION

Last Name | First Name | DOB | Gender ☐ M ☐ F | Last 4 SSN | Primary Language

Address | City | State | ZIP

Email | Home Phone | Work Phone | Cell Phone

Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT

Primary Caregiver/Alt Contact Name (If applicable) | Alt Contact Email | Alt Contact Phone

PRESCRIBER INFORMATION

Name of Contact Sending Referral | Title | Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax

Referral Contact Email | Office Phone | Office Fax

Practice / Facility Name | Prescriber Name / Specialty

Address | City | State | ZIP

Prescriber State License # | DEA # | NPI # | Medicaid UPIN #

*** Please include a copy of the front and back of insurance card ***

CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment ☐ Partial Responder ☐ Non-Responder ☐ Relapser Last Date of Therapy: Product Used: | Therapy Start Date

Anticipated Length of Therapy ☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ 24 weeks ☐ Other: | HCV Genotype ☐ 1a ☐ 1b ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ No Cirrhosis ☐ Compensated Cirrhosis ☐ De-compensated Cirrhosis (CTP: ☐ B ☐ C)

☐ Positive for Q80K Polymorphism ☐ NS5A Polymorphism ☐ Yes ☐ No ☐ NS5A Polymorphism Type ☐ M28 ☐ L31 ☐ Q30 ☐ Y93

Fibrosis Score ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4 | Baseline HCV RNA Viral Load (IU): Date of Labwork:

Liver Biopsy ☐ Yes ☐ No Date of liver biopsy: Results of liver biopsy: ANC: Draw Date: Hgb: Draw Date:

Coinfections ☐ HIV ☐ HBV ☐ Post-Transplant ☐ Pre-Transplant ☐ CKD ☐ Dialysis ☐ Other:

PPI/HS Antagonist use During Treatment ☐ Yes ☐ No Agent use: Patient told to hold ☐ Yes ☐ No

Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty: Date Provided: | Patient Height (cm/in): Weight (kg/lbs): Date Obtained:

Other/Concomitant Medications (please list)

Drug Allergies ☐ NKDA ☐ Yes (please list) | Other Allergies (please list)

Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)

ICD-10 Code ☐ B18.2 Chronic HCV ☐ Other:

PRESCRIPTION INFORMATION - Please Escribe if required by state law

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
☐ Epclusa Tablets	☐ 400 mg/100 mg ☐ 200 mg/50 mg	☐ Take one tablet by mouth once daily with or without food	28	
☐ Epclusa Packets *Pediatric patients 3 years & older Current Weight: ________ lbs / kgs*	☐ 200 mg/ 50 mg ☐ 150 mg/37.5 mg	**<17 kg:** ☐ Take one 150 mg/37.5 mg packet once daily **17 kg to Less than 30 kg:** ☐ Take one 200 mg/50 mg packet once daily **At least 30 kg:** ☐ Take two x 200 mg/50 mg packets (400 mg/100 mg) once daily *Do not chew. Can be taken directly in mouth or with food. Sprinkle on 1 or more spoonfuls of non-acidic soft food (e.g., pudding, ice cream) at or below room temperature. Take within 15 minutes of gently mixing & swallow entire contents.*	4 weeks	
☐ Harvoni Tablets	☐ 90 mg/400 mg ☐ 45 mg/200 mg	☐ Take one tablet by mouth once daily	28	
☐ Harvoni Packets	☐ 33.75 mg/150 mg	☐ Take one packet by mouth once daily	28	
	☐ 45 mg/200 mg	☐ Take one packet by mouth once daily ☐ Take two packets by mouth once daily *Do not chew pellets. May be sprinkled on 1 or more spoonfuls of non-acidic soft foods (e.g., pudding, mashed potatoes, ice cream) at or below room temperature; gently mix. Swallow entire contents within 30 minutes of mixing.*	28 56	
ledipasvir-sofosbuvir Tablet (generic Harvoni)	☐ 90 mg/400 mg	☐ Take one tablet by mouth once daily	28	

Prescriber Signature ________ Date ________ Supervising Physician Signature (where required by state law) ________ Date ________

DAW (Dispense as Written) ________ Date ________ Brand Necessary (must handwrite) ________

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HEPATITIS C REFERRAL FORM (M-Z)

PHONE 888.370.1724 | **FAX** 877.645.7514

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PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language

Address	City	State	ZIP

Email	Home Phone	Work Phone	Cell Phone

Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT

Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax

Referral Contact Email	Office Phone	Office Fax

Practice / Facility Name	Prescriber Name / Specialty

Address	City	State	ZIP

Prescriber State License #	DEA #	NPI #	Medicaid UPIN #

**** Please include a copy of the front and back of insurance card ****

CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment ☐ Partial Responder
☐ Non-Responder ☐ Relapser Last Date of Therapy: Product Used:
Therapy Start Date

Anticipated Length of Therapy
☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ 24 weeks ☐ Other:

HCV Genotype ☐ 1a ☐ 1b ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
☐ No Cirrhosis ☐ Compensated Cirrhosis ☐ De-compensated Cirrhosis (CTP: ☐ B ☐ C)

☐ Positive for Q80K Polymorphism ☐ NS5A Polymorphism ☐ Yes ☐ No ☐ NS5A Polymorphism Type ☐ M28 ☐ L31 ☐ Q30 ☐ Y93

Fibrosis Score ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4
Baseline HCV RNA Viral Load (IU): Date of Labwork:

Liver Biopsy ☐ Yes ☐ No Date of liver biopsy: Results of liver biopsy: ANC: Draw Date: Hgb: Draw Date:

Coinfections ☐ HIV ☐ HBV ☐ Post-Transplant ☐ Pre-Transplant ☐ CKD ☐ Dialysis ☐ Other:

PPI/HS Antagonist use During Treatment ☐ Yes ☐ No Agent use: Patient told to hold ☐ Yes ☐ No

Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty: Date Provided:
Patient Height (cm/in): Weight (kg/lbs): Date Obtained:

Other/Concomitant Medications (please list)

Drug Allergies ☐ NKDA ☐ Yes (please list)
Other Allergies (please list)

Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)

ICD-10 Code ☐ B18.2 Chronic HCV ☐ Other:

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MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ Mavyret Tablets *45 kg & > or 12 years of age & older*	☐ 100 mg/40 mg	☐ Take three tablets by mouth once daily with food	84	
☐ Mavyret Packets *3 years of age & older* *Current Weight:* *______ lbs / kg*	☐ 50 mg/20 mg	**Less than 20 kg:** ☐ Take 3 packets (150 mg/60 mg) by mouth once daily with food **20 kg to Less than 30 kg:** ☐ Take 4 packets (200 mg/80 mg) by mouth once daily with food **30 kg to Less than 45 kg:** ☐ Take 5 packets (250 mg/100 mg) by mouth once daily with food *Sprinkle pellets on small amount of food with low water content (e.g., peanut butter, thick jam, Greek yogurt); swallow within 15 minutes of preparation. Do not crush or chew.*	84 112 140	
☐ Vosevi	☐ 400 mg/100 mg/100 mg	☐ Take 1 tablet by mouth once daily with food	28	
☐ Zepatier	☐ 50 mg/100 mg	☐ Take one tablet by mouth once daily with or without food (Please include results of NS5A resistance testing for GT 1a above)	28	
☐ Ribavirin	☐ 200mg tablets ☐ 200mg capsules	☐ Take _____mg by mouth in the morning and take ______mg by mouth in the evening	4 weeks	
☐ Other				

Prescriber Signature ____________ Date ______ Supervising Physician Signature (where required by state law) ____________ Date ______

DAW (Dispense as Written) ____________ Date ______ Brand Necessary (must handwrite) ____________

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