



HCV REFERRAL FORM

Phone: (855) 896.9255 Fax: (402) 896.4862
10004 S. 152nd St, Suite A, Omaha NE 68138

Patient Information			PLEASE FAX INSURANCE CARD (FRONT AND BACK)			Prescriber Information			
Last Name		First Name		DOB		Practice/Facility Name			
Address						Address			
City		State		ZIP		City		State	ZIP
Phone			SSN			Prescriber Name			
Allergies						Prescriber NPI			
Sex	Male	Female	Weight (kg)		Height (ft,in)	Nurse/Key Contact		Phone/Pager	
Insurance Plan			Plan ID #			Fax		Email	

Diagnosis/Clinical Information		PLEASE FAX CLINICAL AND LAB INFORMATION			
Diagnosis: B18.2 (Chronic HCV)	Other: _____	Treatment Naive: Yes	No (Response): Incomplete Treatment		
Diagnosis Date: ____/____/____		Relapser	Null Responder	Partial Responder	
Genotype: 1 1a* 1b 2 3 4 5		Previous treatment regimen(s): _____			
*NS5A polymorphism type: M28 Q30 L31 Y93 Other: _____		Co-infections: HIV	HBV	Post-Transplant	Pre-Transplant
Baseline viral load HCV RNA: _____ IU		CKD	Dialysis	Other: _____	
Date baseline viral load obtained: ____/____/____		PPI/H2 Antagonist During Treatment?:		Yes	No
Degree of Fibrosis: F1 F2 F3 F4 (Please indicate if cirrhotic.)		If yes, was patient told to hold?		Yes	No
Cirrhosis: None Compensated Decompensated (CTP: B C)					

Additional Information			
Today's Date	Delivery Date	Deliver to: Home Physician	Special Instructions

Existing treatment New Treatment Start **ANTICIPATED OR ACTUAL THERAPY START DATE:** ____/____/____

Prescription Information			
MEDICATION	DOSE/STRENGTH/DIRECTIONS FOR USE	QTY	REFILLS
Epclusa® (velpatasvir 100mg/sofosbuvir 400mg)	Take one tablet by mouth once daily	28	
Harvoni® (ledipasvir 90mg/sofosbuvir 400mg)	Take one tablet by mouth once daily	28	
Mavyret® (glecaprevir 100mg/pibrentasvir 40mg)	Take three tablets by mouth once daily with food	84	
Vosevi® (sofosbuvir 400mg/velpatasvir 100mg/voxilaprevir 100mg)	Take one tablet by mouth once daily with food	28	
Zepatier® (elbasvir 50mg/grazoprevir 100mg)	Take one tablet by mouth once daily (Please include results of NS5A resistance testing for GT 1a)	28	
Ribasphere® (ribavirin) 200mg Tablets/Capsules (unless otherwise specified, pharmacy preference/availability [or insurance preference] will be dispensed)	Take _____mg by mouth every morning and take _____mg by mouth every evening.	28-day	

Anticipated therapy duration: **8 weeks** **12 weeks** **16 weeks** **24 weeks** **Other:**

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 substitution:

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date)

DISPENSE AS WRITTEN/Do Not Substitute (date)

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