



# 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
<b>Epclusa®</b> (velpatasvir 100mg/sofosbuvir 400mg)	Take one tablet by mouth once daily	28	
<b>Harvoni®</b> (ledipasvir 90mg/sofosbuvir 400mg)	Take one tablet by mouth once daily	28	
<b>Mavyret®</b> (glecaprevir 100mg/pibrentasvir 40mg)	Take three tablets by mouth once daily with food	84	
<b>Vosevi®</b> (sofosbuvir 400mg/velpatasvir 100mg/voxilaprevir 100mg)	Take one tablet by mouth once daily with food	28	
<b>Zepatier®</b> (elbasvir 50mg/grazoprevir 100mg)	Take one tablet by mouth once daily (Please include results of NS5A resistance testing for GT 1a)	28	
<b>Ribasphere® (ribavirin) 200mg Tablets/Capsules</b> (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)

I authorize Amber Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer.

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