HCV REFERRAL FORM

Amber PHARMACY
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Patient Information

PLEASE FAX INSURANCE CARD (FRONT AND BACK)

Last Name	First Name	DOB
Address		
City	State	ZIP
Phone	SSN	
Allergies		
Sex ☐ Male ☐ Female	Weight (kg)	Height (ft,in)
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact	Phone/Pager	
Fax	Email	

Diagnosis/Clinical Information

PLEASE FAX CLINICAL AND LAB INFORMATION

Diagnosis: ☐ B18.2 (Chronic HCV) Other:_____

Diagnosis Date: _____/_____/_____

Genotype: ☐ 1 ☐ 1a* ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5

*NS5A polymorphism type: ☐ M28 ☐ Q30 ☐ L31 ☐ Y93 Other: _____

Baseline viral load HCV RNA: _____IU

Date baseline viral load obtained: _____/_____/_____

Degree of Fibrosis: ☐ F1 ☐ F2 ☐ F3 ☐ F4 (Please indicate if cirrhotic.)

Cirrhosis: ☐ None ☐ Compensated ☐ Decompensated (CTP: ☐ B ☐ C)

Treatment Naive: ☐ Yes ☐ No (Response): ☐ Incomplete Treatement ☐ Relapser ☐ Null Responder ☐ Partial Responder

Previous treatment regimen(s): _____

Co-infections: ☐ HIV ☐ HBV ☐ Post-Transplant ☐ Pre-Transplant ☐ CKD ☐ Dialysis ☐ Other: _____

PPI/H2 Antagonist During Treatment?: ☐ Yes ☐ No

If yes, was patient told to hold? ☐ Yes ☐ No

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)

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.