Hepatitis C Referral Form

Faxed prescriptions will only be accepted from an authorized prescriber. Prescribers are reminded patients may choose any pharmacy of their choice

1. Patient Information

Patient Name: _____ Birthdate: _____ Sex: ☐Male ☐Female Weight_____ ☐lbs. ☐kg
Preferred Phone: _____ Known Allergies_____
Address: _____ City: _____ State_____ Zip: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2. Prescriber Information

Prescriber Name: _____ NPI#_____ Tax ID#_____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Key Contact: _____

3. Diagnosis/Clinical Information

Diagnosis/ICD10:
☐ Chronic viral hepatitis C. **B18.2** ☐ **B19.20**
☐ Other_____
Fibrosis Score: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4
Cirrhosis: ☐ None ☐ Compensated ☐ Decompensated
Child-Pugh Score: _____ GFR: ☐ < 60 ☐ >60

Genotype: ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
Viral Load: _____ **Date**: _____
NS5A Polymorphism: ☐ Yes ☐ No
HIV Coinfection: ☐ Yes ☐ No
HBV Coinfection: ☐ Yes ☐ No
HBV Status: _____

Prior Therapy	End Date	Treatment Weeks	Response Status
_____	_____	_____	☐Naïve ☐Null ☐Partial ☐Relapse
_____	_____	_____	☐Naïve ☐Null ☐Partial ☐Relapse

Please FAX recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization

4. Prescription Information

Medication	Dose/Strength	Sig	QTY.	Refills
☐ Daklinza® (daclatasvir)	☐ 60 mg ☐ 30 mg	☐ Take 1 tablet by mouth daily, with or without food	28-day supply	
☐ Epclusa® (sofosbuvir/velpatasvir)	☐ 400 mg/100 mg	☐ Take 1 tablet by mouth daily, with or without food	28-day supply	
☐ Harvoni® (ledipasvir/sofosbuvir)	☐ 90 mg/100 mg	☐ Take 1 tablet by mouth daily, with or without food	28-day supply	
☐ Olysio® (Simeprevir)	☐ 150 mg	☐ Take 1 capsule by mouth daily with food	28-day supply	
☐ Mavyret® (glecaprevir/pibrentasvir	☐ 100 mg/40 mg	☐ Take 3 tablets (1 Pack) by mouth daily with food	28-day supply	
☐ Ribavirin	☐ 200 mg	☐ ≥ 75 KG 600 mg in the morning and 600 mg in the evening ☐ < 75KG 600 mg in the morning and 400 mg in the evening ☐ Other _____mg in the morning and _____mg in the evening	28-day supply	
☐ Vosevi® (sofosbuvir/velpatasvir/ voxilaprevir)	☐ 400 mg/100 mg/ 100 mg	☐ Take 1 tablet by mouth daily with food	28-day supply	
☐ Zepatier® (elbasvir/grazoprevir)	☐ 50 mg/100 mg	☐ Take 1 tablet by mouth daily, with or without food	28-day supply	
☐ Other				

Dispensing Options: ☐ Pick-Up | Deliver To: ☐Patient's Home ☐ Prescriber's Office

Prescriber Signature: Prescriber, please sign and date below	
	Date

I authorize Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.