Phone: 866.209.5540 **Fax: 800.878.4160**

HEPATITIS-C Referral Form

Shipment: Needs By: _____ Ship to: ☐Patient ☐MD Office ☐ Other: _____

Patient Name: _____
Address: _____
_____
Phone: _____
Alternate Phone: _____
DOB: _____ Gender ☐Male ☐Female
Last 4 digits of social: _____
Emergency Contact: _____

Prescriber Name: _____
DEA: _____
NPI: _____
Address:

Phone:
Fax:
Contact Person:

INSURANCE INFORMATION & CLINICAL INFORMATION

Primary Insurance: *attach cards ☐
Insurance Carrier: _____ ID#: _____
☐ New Start ☐ Continuation of Therapy ☐ PA Only Length of Treatment**:** ☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ 24 weeks

Diagnosis: ***attach labs/chart notes**
☐ B18.2 Chronic Hepatitis- C Other: _____
☐ Liver Biopsy ☐CT Scan ☐Ultrasound Grade _____ Stage _____ ☐ Fibrosure Lab, Score _____
Genotype: _____ Viral load: _____
☐Naïve to TX ☐Partial Responder ☐Relapser ☐Null Response Dates of Previous Therapy: _____
HIV Status ☐Positive ☐Negative HBV Labs (HBsAg & anti-HBc) ☐ ***required & attach**
Drug/Alcohol Screen ☐ ☐NS5A resistance-associated test

Prescription Information

☐ **Mavyret** (glecaprevir and pibrentasvir) Qty: 84
300mg/120mg
Take 3 tablets once daily with food Refill: _____

☐ **Daklinza** (daclatasvir) Qty: 28
☐ 60mg Tablet
☐ 30mg Tablet
Take 1 tablet by mouth once daily Refill: _____

☐ **Zepatier** (elbasvir / grazoprevir) Qty: 28
50mg/100mg tablet
Take 1 tablet daily with or without food Refill: _____
NS5A resistance-associated test required (1a)*

☐ **Sovaldi** (sofosbuvir) Qty: 28
400 mg tablet
Take 1 tablet by mouth once daily Refill: _____

☐ **Harvoni** (ledipasvir/sofosbuvir) Qty: 28
90mg/400 mg tablet
Take 1 tablet by mouth once daily Refill:_____
☐ **Authorized Generic Harvoni** Qty: 28
(Ledipasvir 90mg/Sofosbuvir 400 mg) Refill:_____
Take 1 tablet by mouth once daily

☐ **Ribasphere (ribavirin)** tablet or capsule x 200mg
Take _____ tab(s)/cap(s) QAM
Take _____ tab(s)/cap(s) QPM
☐ Qty: 140 <75 kg (165 lbs) = 1000 mg daily
☐ Qty: 168 ≥75 kg (166 lbs) = 1200 mg daily
☐ Qty: _____

☐ **Epclusa (sofosbuvir /Velpatasvir**) Qty: 28
400mg/100 mg tablet
Take 1 tablet by mouth once daily Refill:_____

☐ **Technivie** (ombitasvir/paritaprevir/ritonavir) Qty: 56
12.5 mg/75mg/50mg tablets
Take 2 tablets by mouth once daily Refill: _____

☐ **Authorized generic Epclusa**
(sofosbuvir/velpatasvir) Qty: 28
400mg/100mg tablet
Take 1 tablet by mouth once daily Refill: _____

☐ **Vosevi** (sofosbuvir, velaptasvir, voxilaprevir) Qty: 28
400mg/100mg/100mg tab
Take 1 tablet daily with food Refill: _____
HBsAg & anti-HBc test required*

Prescribers Signature: _____ _____ **Date:** _____
PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

I authorized VitalRx Pharmacy to act on behalf of the prescriber to initiate and complete the prior authorization process including, but not limited to, acquiring any necessary labs, clinic notes and/or imaging.

Revised: 8/4/2017