Priority Health Pharmacy
Phone: 845-789-5648
Fax: 845-789-4104
NCDPD 5851476
NPI 1457297335

HEPATITIS C REFERRAL FORM

Patient Name _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

Please Fax Insurance Card(s) both sides
Insured's Name _____
Relation to Patient _____
Primary Insurance _____
ID# _____ Group # _____
Secondary Insurance _____
ID# _____ Group # _____

Ordering Prescriber _____
Office Contact _____
Street Address _____ Suite #_____
City _____ State _____ Zip _____
Tel _____ Fax _____
Email _____
License# _____
NPI# _____

ICD-10 Code ☐ **B18.2 HCV** (Chronic)
☐ **Yes** ☐ **No** Is patient co-infected with HIV?
☐ **Yes** ☐ **No** Interferon ineligible?
☐ **Yes** ☐ **No** Does Patient have Cirrhosis?
☐ **Yes** ☐ **No** Drug and Alcohol Screening
If no, patient must obtain test
☐ **Yes (naïve)** ☐ **No** Is Patient treatment naïve?
If No, what drugs _____ # of Weeks _____ ☐ relapsed ☐ partial response ☐ null response

Genotype* ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 6
_____ Pretreatment (Viral Load)
_____ Current Treatment (Viral Load)
_____ HCV RNA Viral Load* on Date _____
_____ Fibrosis Score/Test (stage)*
_____ Fibroscan KPA
_____ Metavir Score (F0-F4)

Please forward all pertinent chart notes and lab results for prior authorization

PRESCRIPTION

FOR ALL MEDICATIONS QTY/REFILL:
☐ **8 weeks (no cirrhosis)** ☐ **12 weeks (cirrhosis)**

EPCLUSA Sofosbuvir 400 mg/Velpatasvir 100 mg tablet
SIG: ☐ Take 1 tab 1x day for 12 weeks
☐ Take 1 tab 1x day for 12 weeks WITH ribavirin

DAKLINZA **GT 1 & 3 ONLY**
☐ 30 mg w/ 400 mg SOVALDI ☐ 60 mg w/ 400 mg SOVALDI
SIG: Take 1 tablet each daily

☐ **HARVONI** Ledipasvir 90 mg / Sofosbuvir 400 mg
SIG: Take 1 tablet by mouth daily

☐ **MAVYRET** 100 mg glecaprevir/40 mg pibrentasvir tablet
SIG: ☐ Take 3 tablets PO once daily with food
Total daily dose: glecaprevir 300 mg and pibrentasvir 120 mg
☐ Other:_____

☐ **TECHNIVIE** Paritaprevir/Ritonavir (75/50mg) & Ombitasvir (12.5mg) **GT 4 ONLY**
SIG: ☐ Take two tablets QAM with meal and with RIBAVIRIN

☐ **VOSEVI** 400 mg sofosbuvir/100 mg velpatasvir/100 mg voxilaprevir tablet
SIG: ☐ Take 1 tablet PO daily with food for 12 weeks
☐ Other:_____

☐ **ZEPATIER** Grazoprevir 100mg/ Elbasvir 50mg tab **GT 1 & 4 ONLY**
NS5A test for GT1a patients ☐ Yes ☐ No ☐ 12 weeks ☐ 16 weeks
SIG: Take one tablet PO daily
with Ribavirin? ☐ No ☐ Yes: See Ribavirin box for dosages

☐ **RIBAVIRIN** ☐ **RIBAPAK** ☐ **MODERIBA**
Dosing
☐ 600 mg/day 200 mg QAM 400 mg QPM
☐ 800 mg/day 400 mg QAM 400 mg QPM
☐ 1000 mg/day 600 mg QAM 400 mg QPM
☐ 1200 mg/day 600 mg QAM 600 mg QPM
☐ 200 mg SIG: _____
☐ Other:_____

☐ **VIEKIRA XR**
Dasabuvir 200mg/ Ombitasvir 8.33mg/ Paritaprevir 50mg/ Ritonavir 33.33mg
SIG: Take 3 tablets PO with meal for:
☐ 12 weeks w/ Ribavirin (GT 1a, w/o cirrhosis)
☐ 24 weeks w/ Ribavirin (GT1a, w/ compensated cirrhosis)
☐ 12 weeks (GT 1b, w/ or w/o compensated cirrhosis)

☐ **VIEKIRA PAK** Ombitasvir/Paritaprevir/Ritonavir 12.5mg/75 mg/50 mg tabs (pink)
Dasabuvir 250 mg tab (beige)
Directions: Take 2 pink tabs PO once daily (AM) with food and one beige tab PO twice daily (AM and PM) with food

SUPPORTIVE THERAPIES Strength _____
☐ Procrit ☐ Epogen ☐ Neulasta ☐ Aranesp ☐ Neupogen
SIG: _____ QTY:_____ Refill: _____

HEPATITIS B ORAL THERAPIES
☐ Baraclude ☐ 0.5 mg ☐ 1.0 mg
☐ Epivir HBV 100 mg ☐ Hepsara 10 mg ☐ Tyzeka 600 mg
Additional Directions: _____
☐ 1 Tablet PO QD QTY: ☐ 1 Month ☐ 3 Month

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS)_____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.
My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.