Date:_____

Hepatitis C Referral

PATIENT NAME: _____

Address: _____
City, State, Zip: _____
Cell Phone: _____ Home Phone: _____
Weight: _____ Language: _____
Date of Birth: _____ Gender: ☐ Male ☐ Female
Guardian/Caregiver & Number: _____
Insurance Plan: _____ ID: _____
☐ Attach the front & back of insurance card (medical & prescription)

PRESCRIBER NAME: _____

Address: _____
City, State, Zip: _____
Phone: _____ Alternative: _____
Fax: _____
Practice Name: _____
DEA: _____ NPI: _____
Office Contact: _____
Email: _____

CLINICAL INFORMATION ***Provide Clinical Notes/Labs from most recent visit***

Diagnosis/ICD-10_____ **Genotype**: ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 **Viral Load:** _____ **Date:**_____

Cirrhosis:☐ None ☐ Compensated ☐ Decompensated **Child-Pugh:**☐ A ☐ B ☐ C **Transplant status:**☐ N/A ☐ Pre-transplant ☐ Post-transplant

Fibrosis Score:☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4 **Polymorphism**: IL-28: ☐ CC ☐ CT ☐ TT NS5A: ☐ 28 ☐ 30 ☐ 31 ☐ 93 ☐ _____ ☐ Q80K

Co-Infection: ☐ None ☐ HIV ☐ HBV **sCr**: _____ **GFR**: _____ **Date**: _____ **CKD state**: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Known Allergies: _____ ☐ **Treatment Naive** ☐ **Treatment Experienced: Prior Treatment**_____

Treatment Weeks: _____ **End Date:**_____ **Reasons for Stopping:** _____

Medication	Directions	Quantity x 28 day supply	Refills
☐ **Daklinza** (daclatasvir)	☐ Take1 tablet by mouth once daily * Reduce to 30mg once daily with strong CYP3A inhibitors or increase to 90mg once daily with moderate CYP3A inducers*	☐ 28 x 30 mg tablets ☐ 28 x 60 mg tablets ☐ 28 x 90 mg tablets	
☐ **Epclusa** (sofosbuvir/velpatasvir)	☐ Take 1 tablet by mouth once daily	☐ 28 x 400 mg/100 mg tablets	
☐ **Harvoni** (ledipasvir/sofosbuvir)	☐ Take 1 tablet by mouth once daily	☐ 28 x 90 mg /400 mg tablets	
☐ **Mavyret** (glecaprevir/pibrentasvir)	☐ Take 3 tablets by mouth once daily with food	☐ 84 x 100 mg/40 mg tablets	
☐ **Olysio** (simeprevir)	☐ Take 1 capsule by mouth once daily	☐ 28 x 150 mg capsules	
☐ **Ribapak dose pak** ☐ **Moderiba dose pak** ☐ **RibaSphere** (generic ribavirin)	☐ Take 400mg PO QAM, Take 200mg PO QPM ☐ Take 400mg PO QAM, Take 400mg PO QPM ☐ Take 600mg PO QAM, Take 400mg PO QPM ☐ Take 600mg PO QAM, Take 600mg PO QPM ☐ Other: _____	☐ 200/400 mg ☐ 600/400 mg ☐ 400/400 mg ☐ 600/600 mg ☐_____ x 200 mg ☐ Capsules ☐ Tablets ☐ Okay to substitute Ribapak/Moderiba with Ribavirin if nonformulary	
☐ **Sovaldi** (sofosbuvir)	☐ Take 1 capsule by mouth once daily	☐ 28 x 400 mg capsules	
☐ **Technivie** (ombitasvir/paritaprevir/ritonavir)	☐ Take 2 tablets by mouth in the morning with food.	☐ 56 x 12.5 mg/75 mg/50 mg tablets	
☐ **Viekira Pak** (dasabuvir/ombitasvir/paritaprevir/ritonavir)	☐ Take 3 tablets by mouth in the morning and take 1 tablets by mouth in the evening with food.	☐ 112 x 250 mg/12.5 mg /75 mg/50 mg tablets	
☐ **Viekira XR** (dasabuvir/ombitasvir/paritaprevir/ritonavir)	☐ Take 3 tablets by mouth once daily with food	☐ 84 x 200 mg/8.33 mg /50 mg/33.33mg tablets	
☐ **Vosevi** (sofosbuvir/velpatasvir/voxilaprevir)	☐ Take 1 tablet by mouth once daily with food	☐ 28 x 400 mg/100 mg/100 mg tablets	
☐ **Zepatier** (elbasvir/grazoprevir)	☐ Take 50 mg/100 mg by mouth once daily	☐ 28 x 50 mg/100 mg tablets	
☐ **Other**_____	☐ Other: _____	☐ 1 month supply	

Intended combination therapy duration: ☐ 8 Weeks ☐ 12 Weeks ☐ 16 Weeks ☐ 24 Weeks ☐ Other: _____

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program.
Patient Signature:_____ Date: _____

Prescriber Signature: Stamp signature not allowed, physician signature required Verbal Readback ☐ Yes ☐ No

X_____ X_____ Date: _____

Dispense as written Product substitution permitted