

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Needs by Date: \_\_\_\_\_

Language: \_\_\_\_\_  Nursing Instruction Required

Ship to:  Patient  MD Office

## HEPATITIS C REFERRAL FORM

Prescriber's Name: \_\_\_\_\_ DEA #: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Office Contact: \_\_\_\_\_

### PATIENT INFORMATION: Please complete the following or send patient demographic sheet

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  F  M

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate: \_\_\_\_\_ Email: \_\_\_\_\_

### PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION

Diagnosis:  B18.2 (Chronic Hepatitis C Virus) Diagnosis date: \_\_\_\_\_ Transplant status:  N/A  Pre-transplant  Post-transplant  
 Genotype:  1  2  3  4  5  6 Subtype:  A  B  A/B  N/A sCr: \_\_\_\_\_ GFR: \_\_\_\_\_ Date: \_\_\_\_\_  
 Baseline viral load: \_\_\_\_\_ Date: \_\_\_\_\_ CKD stage:  1  2  3  4  5  N/A Dialysis:  Yes  No  
 Degree of fibrosis:  F0  F1  F2  F3  F4  TT IL28B polymorphism:  CC  CT  TT  
 Cirrhosis:  None  Compensated  Decompensated (CTP:  B  C) Q80K polymorphism:  Yes  No NS5A polymorphism:  Yes  No  
 Co-infection(s):  None  HIV  HBV NS5A polymorphism type:  M28  Q30  L31  Y93  \_\_\_\_\_

Prior Regimen <input type="checkbox"/> Naive <input type="checkbox"/> Experienced (List below)	Start Date	End Date	Treatment Weeks	Response *
_____	_____	_____	_____	<input type="checkbox"/> IC <input type="checkbox"/> NR <input type="checkbox"/> PR <input type="checkbox"/> RLP
_____	_____	_____	_____	<input type="checkbox"/> IC <input type="checkbox"/> NR <input type="checkbox"/> PR <input type="checkbox"/> RLP
_____	_____	_____	_____	<input type="checkbox"/> IC <input type="checkbox"/> NR <input type="checkbox"/> PR <input type="checkbox"/> RLP

\*Response definitions: IC - Incomplete treatment, NR - Null Responder, PR - Partial Response, RLP - Relapser

Comorbidities: \_\_\_\_\_

Concomitant Medications: \_\_\_\_\_

Allergies:  NKDA  Other: \_\_\_\_\_

### PRESCRIPTION

		QUANTITY	DURATION	REFILL
<input type="checkbox"/> <b>Daklinza</b> <sup>®</sup> (daclatasvir)	<input type="checkbox"/> Take 30 mg by mouth once daily <input type="checkbox"/> Take 60 mg by mouth once daily <input type="checkbox"/> Take 90 mg by mouth once daily	<input type="checkbox"/> 28 x 30 mg tablets <input type="checkbox"/> 28 x 60 mg tablets <input type="checkbox"/> 28 x 90 mg tablets	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks	_____
<input type="checkbox"/> <b>Epclusa</b> <sup>®</sup> (velpatasvir/sofosbuvir)	<input type="checkbox"/> Take 100 mg/400 mg by mouth once daily	<input type="checkbox"/> 28 x 100 mg/400 mg tablets	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks	_____
<input type="checkbox"/> <b>Harvoni</b> <sup>®</sup> (ledipasvir/sofosbuvir)	<input type="checkbox"/> Take 90 mg/400 mg by mouth once daily	<input type="checkbox"/> 28 x 90 mg/400 mg tablets	<input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks	_____
<input type="checkbox"/> <b>Mavyret</b> <sup>™</sup> (glecaprevir + pibrentasvir)	<input type="checkbox"/> Take 3 tablets by mouth once daily with food	<input type="checkbox"/> 84 x 100 mg/40mg tablets	<input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> 16 weeks	_____
<input type="checkbox"/> <b>Olysio</b> <sup>®</sup> (simeprevir)	<input type="checkbox"/> Take 150 mg by mouth once daily	<input type="checkbox"/> 28 x 150 mg capsules	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks	_____
<input type="checkbox"/> <b>Sovaldi</b> <sup>®</sup> (sofosbuvir)	<input type="checkbox"/> Take 400 mg by mouth once daily	<input type="checkbox"/> 28 x 400 mg tablets	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks	_____
<input type="checkbox"/> <b>Technivie</b> <sup>™</sup> (ombitasvir/paritaprevir/ritonavir)	<input type="checkbox"/> Take 2 tablets by mouth in the morning with food	<input type="checkbox"/> 56 x 12.5 mg/75 mg/50 mg tablets	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks	_____
<input type="checkbox"/> <b>Viekira Pak</b> <sup>®</sup> (dasabuvir/ombitasvir/paritaprevir/ritonavir)	<input type="checkbox"/> Take 3 tablets by mouth in the morning and 1 tablet by mouth in the evening with food	<input type="checkbox"/> 112 x 250 mg/12.5 mg/75 mg/50 mg tablets	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks	_____
<input type="checkbox"/> <b>Viekira XR</b> <sup>™</sup> (dasabuvir/ombitasvir/paritaprevir/ritonavir)	<input type="checkbox"/> Take 3 tablets by mouth once daily with food	<input type="checkbox"/> 84 x 200 mg/8.33 mg/50 mg/33.33 mg tablets	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks	_____
<input type="checkbox"/> <b>Vosevi</b> <sup>™</sup> (sofosbuvir/velpatasvir/voxilaprevir)	<input type="checkbox"/> Take 1 tablet by mouth once daily with food	<input type="checkbox"/> 28 x 400 mg/100 mg tablets	<input type="checkbox"/> 12 weeks	_____
<input type="checkbox"/> <b>Zepatier</b> <sup>™</sup> (elbasvir/grazoprevir)	<input type="checkbox"/> Take 50 mg/100 mg by mouth once daily	<input type="checkbox"/> 28 x 50/100 mg tablets	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 16 weeks	_____
<input type="checkbox"/> <b>Ribasphere</b> <sup>®</sup> <b>Ribapak</b> <sup>®</sup> <b>Dose Pak</b> (ribavirin)	<input type="checkbox"/> Take _____ mg tablet by mouth every morning, _____ mg tablet by mouth every evening (_____ mg/day)	<input type="checkbox"/> 28 x 200 mg; 28 x 400 mg <input type="checkbox"/> 28 x 400 mg; 28 x 400 mg <input type="checkbox"/> 28 x 400 mg; 28 x 600 mg <input type="checkbox"/> 28 x 600 mg; 28 x 600 mg	Tablets	_____
<input type="checkbox"/> <b>Moderiba</b> <sup>™</sup> <b>Dose Pack</b> (ribavirin)	<input type="checkbox"/> Take _____ mg tablet by mouth every morning, _____ mg tablet by mouth every evening (_____ mg/day)	<input type="checkbox"/> _____ x 200 mg	<input type="checkbox"/> Tablets <input type="checkbox"/> Capsules	_____

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**IMPORTANT NOTICE:** This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the center at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitter material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.

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