ameripharma SPECIALTY CARE

HEPATITIS C REFERRAL FORM

Phone#: 877-778-0318 Fax#: 877-778-0399

Patient Information

Patient Name: ______ DOB: ______ Sex: ☐ Male ☐ Female SSN: ______ Wt (kg/lbs): ______ Ht (cm/in): ______

Address: ______ Phone: ______ Alternate: ______

Caregiver Name: ______ Relation to Patient: ______ Phone: ______

Insurance Plan: ______ Plan ID: ______ BIN #: ______ PCN #: ______ GRP #: ______

Please fax a copy of the front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber Name: ______ DEA: ______ NPI: ______

Address: ______

Phone: ______ Alternate: ______ Fax: ______ Email: ______

If shipping to prescriber: ☐ First Fill ☐ Always ☐ Never

Clinical Information (Please fax all pertinent clinical and lab 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: ______

Base viral load: ______ Date: ______

CKD stage: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ N/A Dialysis: ☐ Yes ☐ No

Degree of fibrosis: ☐ F0 ☐ F1 ☐ F3 ☐ F4 ☐ ______

IL28B polymorphism: ☐ CC ☐ CT ☐ TT

Cirrhosis: ☐ None ☐ Compensated ☐ Decompensated (CTP: ☐ B ☐ C)

Q80K polymorphism: ☐ Yes ☐ No NS5A polymorphism: ☐ Yes ☐ No

Coinfection(s): ☐ None ☐ HIV ☐ HBV

NS5A polymorphism type: ☐ M28 ☐ Q30 ☐ L31 ☐ Y93 ☐ ______

Prior Regimen ☐ Naïve ☐ Experienced (List below)	Start Date	End Date	Treatment Weeks	Response
______	______	______	______	☐ Incomplete treatment ☐ Null Responder ☐ Partial Response ☐ Relapser
______	______	______	______	☐ Incomplete treatment ☐ Null Responder ☐ Partial Response ☐ Relapser
______	______	______	______	☐ Incomplete treatment ☐ Null Responder ☐ Partial Response ☐ Relapser

Comorbidities: ______

Concomitant Medications: ______

Allergies: ☐ NKDA ☐ Other: ______

Prescription	Directions, Quantity, Duration, Form			Refill
☐ **Epclusa®** (velpatasvir/sofosbuvir)	☐ Take 100 mg/400 mg by mouth once daily	☐ 28 x 100 mg/400 mg tablets	☐ 12 weeks ☐ 24 weeks	
☐ **Harvoni®** (ledipasvir/sofosbuvir)	☐ Take 90 mg/400 mg by mouth once daily	☐ 28 x 90 mg/400 mg tablets	☐ 8 weeks ☐ 12 weeks ☐ 24 weeks	
☐ **Mavyret®** (glecaprevir/pibrentasvir)	☐ Take 3 tablets by mouth once daily with food	☐ 84 x 100 mg/40 mg tablets	☐ 8 weeks ☐ 12 weeks ☐ 16 weeks	
☐ **Ribavirin 200mg tab / cap** [ ] Wt. less than 75kg -- 1000mg/day [ ] Wt. 75kg or more -- 1200mg/day	☐ Take ______ 200mg tablet / capsule by mouth every morning ☐ Take ______ 200mg tablet / capsule by mouth every evening	☐ 140 x 200mg ☐ 168 x 200mg	☐ Tablet ☐ Capsule	
☐ **Vosevi®** (sofosbuvir/velpatasvir/voxilaprevir)	☐ Take 1 tablet by mouth once a day	☐ 28 x 400 mg/100 mg/100 mg	☐ 12 weeks	
☐ **Zepatier™** (elbasvir/grazoprevir)	☐ Take 50 mg/100 mg by mouth once daily	☐ 28 x 50/100 mg tablets	☐ 12 weeks ☐ 16 weeks	

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: ______

Prescriber's Signature: ______ Date: ______

I authorize AmeriPharma and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to AmeriPharma.

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