

HEPATITIS C REFERRAL FORM

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

	D	atient Inform	antio		THORIEM: 077	70 0310	Ιαλπ. 077-77	0 0377
Patient Name				Sex: □Male □ Female SSN:			Ht (cm/i	n):
Patient Name:Address:								
Caregiver Name:				THORE				
<u> </u>				PCN #:				
				the insurance card(s			···	
Prescriber + Shipping Information								
Prescriber Name:		DEA	:		NPI:			
Address:								
Phone: Alternate:		Fax:		Ema	il:			
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	s date:		Tran	splant status: N/A	☐ Pre-transplant	☐ Post	-transplant	
Genotype: □1 □2 □3 □4 □5 □6 Subtype: □	□A □B □A/B □N	N/A	sCr:		GFR:		Date:	
Base viral load: Date:			CKD	stage: □ 1 □ 2 □ 3	B □4 □5 □N//	A Dialy:	sis: 🗆 Yes	□ No
Degree of fibrosis: □F0 □F1 □F3 □F4 □ IL28B polymorphism: □CC □CT □TT								
Cirrhosis: ☐ None ☐ Compensated ☐ Decompensated	(Child-Pugh Score:	□B □C)	Q80ł	K polymorphism: 🗆 Y	es □No NS5Ap	olymorph	ism: □ Yes □	∃No
Coinfection(s): ☐ None ☐ HIV ☐ HBV			NS5A	A polymorphism type	: □ M28 □ Q30 □	L31 □ Y9	3 □ Other: _	
Prior Regimen ☐ Naïve ☐ Experienced (List below) St	art Date	End Date		Treatment Weeks	Response	Null	Partial	
					Incomplete I	Muli	Partial □Response _Partial	Relapser
					Incomplete I	Nulİ	□ Response _ Partial	Relapser
					□treatment □i	Responder	Response	Relapser
Comorbidities:								
Concomitant Medications:								
Allergies: NKDA Other: Directions, Quantity, Duration, Form Refill								
		Directions	, Qua	intity, Duration, i	roriii			
☐ Epclusa® (velpatasvir/sofosbuvir) 100mg/400mg tablet	Take 1 tablet by	Take 1 tablet by mouth once daily					☐ 12 weeks, #28 + 2 refills ☐ 24 weeks, #28 + 5 refills	
☐ Harvoni®	Take 1 tablet by	blet by mouth once daily				☐ 8 weeks, #28 + 1 refill ☐ 12 weeks, #28 + 2 refills		
(ledipasvir/sofosbuvir) 90mg/400mg tablet	Tune Transfer by	Take I tablet by mount once daily					☐ 12 weeks, #28 + 2 refills ☐ 24 weeks, #28 + 5 refills	
☐ Mavyret® (glecaprevir/pibrentasvir) 100mg/40mg tablet Take 3 tablets by mouth once daily wit				ith food		□12	veeks, #84 + 1 weeks, #84 + 2	2 refills
(giecapievii/pibieittasvii) Tootiig/40tiig tablet							☐ 16 weeks, #84 + 3 refills	
Ribavirin 200mg tab / cap ☐ Tablets	T					#	_ for 28 day su	vlaaı
☐ Capsules	Take tablet / capsule by mouth every morning							
Wt. less than 75kg 1000mg/day (5 tabs) Wt. 75kg or more 1200mg/day (6 tabs)	Take tablet / capsule by mouth every evening						Refills:	
☐ Vosevi ® (sofosbuvir/velpatasvir/voxilaprevir) 400mg/100mg/100mg tablet	Take 1 tablet by mouth once a day						☐ 12 weeks, #28 + 2 refills	
□ Zepatier™	- 1	-1.2.11.1					☐ 12 weeks, #28 + 2 refills	
(elbasvir/grazoprevir) 50mg/100mg tablet	/100mg tablet Take 1 tablet by mouth once daily						☐ 16 weeks, #28 + 3 refills	
Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise:								
Prescriber's Signature: Date:								
l 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.								

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, bease note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 877-778-0318 to obtain instructions as to the proper destruction of the transmitted material. Thank you.