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: _____

Genotype: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Subtype: ☐A ☐B ☐A/B ☐N/A

Base viral load: _____ Date: _____

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

Cirrhosis: ☐ None ☐ Compensated ☐ Decompensated (Child-Pugh Score: ☐B ☐C)

Coinfection(s): ☐ None ☐ HIV ☐ HBV

Transplant status: ☐N/A ☐Pre-transplant ☐Post-transplant

sCr: _____ GFR: _____ Date: _____

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

IL28B polymorphism: ☐CC ☐CT ☐TT

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

NS5A polymorphism type: ☐M28 ☐Q30 ☐L31 ☐Y93 ☐ Other: _____

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) 100mg/400mg tablet	Take 1 tablet by mouth once daily	☐12 weeks, #28 + 2 refills ☐24 weeks, #28 + 5 refills
☐ **Harvoni®** (ledipasvir/sofosbuvir) 90mg/400mg tablet	Take 1 tablet by mouth once daily	☐8 weeks, #28 + 1 refill ☐12 weeks, #28 + 2 refills ☐24 weeks, #28 + 5 refills
☐ **Mavyret®** (glecaprevir/pibrentasvir) 100mg/40mg tablet	Take 3 tablets by mouth once daily with food	☐8 weeks, #84 + 1 refill ☐12 weeks, #84 + 2 refills ☐16 weeks, #84 + 3 refills
Ribavirin 200mg tab / cap ☐ Tablets ☐ Capsules Wt. less than 75kg -- 1000mg/day (5 tabs) Wt. 75kg or more -- 1200mg/day (6 tabs)	Take _____ tablet / capsule by mouth every morning Take _____ tablet / capsule by mouth every evening	#____ for 28 day supply Refills: _____
☐ **Vosevi®** (sofosbuvir/velpatasvir/voxilaprevir) 400mg/100mg/100mg tablet	Take 1 tablet by mouth once a day	☐12 weeks, #28 + 2 refills
☐ **Zepatier™** (elbasvir/grazoprevir) 50mg/100mg tablet	Take 1 tablet by mouth once daily	☐12 weeks, #28 + 2 refills ☐16 weeks, #28 + 3 refills

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.