

HEPATITIS C REFERRAL FORM

PATIENT INFORMATION			
Patient Name:		DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
SSN:	Phone:	Allergies:	
Address:		City:	State: Zip:
Emergency Contact:		Phone:	<input type="checkbox"/> Please attach demographic information
PRESCRIBER INFORMATION			
Prescriber:		NPI:	DEA: State Lic:
Supervising Physician:		Practice Name:	
Address:		City:	State: Zip:
Phone:	Fax:	Key Office Contact:	Phone:
INSURANCE INFORMATION			
<input type="checkbox"/> Please attach front and back of patient's insurance card (medical and prescription)			
COPAY CARD ENROLLMENT			
<input type="checkbox"/> Please check if enrolling in copay card		Copay ID:	
DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT			
Diagnosis Code: <input type="checkbox"/> B18.2 <input type="checkbox"/> B18.1 <input type="checkbox"/> Other ICD 10 _____ <input type="checkbox"/> Treatment naïve <input type="checkbox"/> Treatment experienced <input type="checkbox"/> Decompensated Cirrhosis <input type="checkbox"/> Compensated Cirrhosis If applicable: <input type="checkbox"/> Co-infected HIV/HCV <input type="checkbox"/> HBV/HCV Prior therapies and reasons for stopping (if applicable) _____ Other medications patient is currently taking (including OTC medications): _____ Please attach the following information:			
<input type="checkbox"/> Clinical Notes from most recent office visit. <input type="checkbox"/> Genotype – Copy of lab report. <input type="checkbox"/> CBC / including ALT, AST, SCr, etc. (Drawn in the past 90 days) <input type="checkbox"/> Urine drug screen (If applicable) <input type="checkbox"/> NS5A resistance-associated polymorphisms lab (If applicable) <input type="checkbox"/> PT/NR – Prothrombin Time and International Normalize Ratio		<input type="checkbox"/> Viral Load – HCV-RNA (Drawn in the past 90 days) <input type="checkbox"/> Treatment readiness assessment (if applicable) <input type="checkbox"/> Fibrosis Score – Attach one of the following reports: Imaging/Fibrosure/Fibroscan/Fibrometer/Hepascore <input type="checkbox"/> Transplant status	
PRESCRIPTION INFORMATION			
<input type="checkbox"/> Epclusa® OR <input type="checkbox"/> generic sofosbuvir/velpatasvir (if available) <input type="checkbox"/> 400 mg/100 mg tablet OR PEDIATRIC 17kg – 30kg: <input type="checkbox"/> 200 mg/50 mg tablet 1 tablet PO once daily OR Other: _____		QTY: <u>1 month</u> Refills: _____	
<input type="checkbox"/> Harvoni® OR <input type="checkbox"/> generic ledipasvir/sofosbuvir (if available) <input type="checkbox"/> 90 mg/400 mg tablet OR PEDIATRIC <17kg: <input type="checkbox"/> 33.75 mg/150 mg pellet 17kg – 35kg: <input type="checkbox"/> 45 mg/200 mg pellet <input type="checkbox"/> 45 mg/200 mg tablet 1 tablet/packet PO once daily OR Other: _____		QTY: <u>1 month</u> Refills: _____	
<input type="checkbox"/> Sovaldi® (sofosbuvir) 400 mg tablet 1 tablet PO once daily		QTY: <u>1 month</u> Refills: _____	
<input type="checkbox"/> Mavyret (glecaprevir and pibrentasvir) 100 mg/40 mg tablet 3 tablets PO once daily with food		QTY: <u>1 month</u> Refills: _____	
<input type="checkbox"/> Ribavirin <input type="checkbox"/> 200 mg tablet <input type="checkbox"/> 200 mg capsule <input type="checkbox"/> Directions: _____		QTY: <u>1 month</u> Refills: _____	
<input type="checkbox"/> Vosevi (sofosbuvir/velpatasvir/voxilaprevir) 400 mg/100 mg/100 mg tablet 1 tablet PO once daily with food		QTY: <u>1 month</u> Refills: _____	
<input type="checkbox"/> Zepatier™ (elbasvir/grazoprevir) 50 mg/100 mg tablet 1 tablet PO once daily NS5A resistance-associated polymorphisms: <input type="checkbox"/> None <input type="checkbox"/> M28 <input type="checkbox"/> Q30 <input type="checkbox"/> L31 <input type="checkbox"/> Y93		QTY: <u>1 month</u> Refills: _____	
<input type="checkbox"/> Other: _____		QTY: _____ Refills: _____	
Intended combination therapy duration: <input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> 16 weeks <input type="checkbox"/> 24 weeks <input type="checkbox"/> Other: _____			
<small>I authorize AcariaHealth to enroll me in a manufacturer-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to: injection training. I further authorize the release to the corresponding manufacturer the minimum necessary information about my health condition and prescriptions to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis, and provide educational information regarding therapies. I understand that I may revoke this authorization at any time in writing by sending a letter to AcariaHealth 6923 Lee Vista Blvd, Suite 300 Orlando, FL 32822. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. A copy of this authorization will be utilized with the same effectiveness as the original. Patient Signature: _____ Date: _____</small>			

Prescriber's Signature: _____ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

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AcariaHealth™

Specialty Pharmacy

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