

Date Shipment Needed: Ship To: □Patient □Prescriber $\square \ \text{Nursing needed; } \square \text{Training needed} \blacktriangleright \text{ All the supplies including syringes and needles will be dispensed if needed.}$

Patient Signature:

_ Date:

Patent Name:	hone: 800.511.5144 • Fax: 877.54	11.1503	HEPAIIIIS	C REFERRAL FURIM			
Phone: Allergies: Oity: State: Zip:	ATIENT INFORMATION						
Other State Description Description					Sex: □M □F	Weight:	□lbs. □kg.
Please attach for galenties Please attach demographic information		hone:		_ · ·			
Prescriber: NPI: DEA: State Lic:			1=-				
Prescriber: Practice Name: Address: Orly: State: Zip:			Phone:		Please attach demog	raphic information	
Paradice Name:			l			Tax	
City: State: Zip: Phone: Zip:			NPI:		DEA:	State Lic:	
Phone: Fax: Key Office Contact: Phone:					0	T	
Pilease attach from and back of patient's insurance card (medical and prescription)		Te			State:		
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Image: Please check if enrolling in copay card Copay ID:		ationtic incurrence coul (mad	lical and proce	windian)			
		nationt's insurance card (med	iicai and presc	ription)			
Diagnosis Code: B18.2 B18.1 Other (CD 10		v card Conav ID:					
Treatment narive realment experienced Decompensated Cirrhosis Compensated Cirrhosis If applicable: Co-infected HIV/HCV HBV/HCV Plor/ therapies and reasons for stopping (if applicable) Cother medications patient is currently taking (including OTC medications):							
If applicable: \ \text{Co-infected HIV/HCV} \ \text{Piot therapies and reasons for stopping (if applicable)} \ \text{Other medications patient is currently taking (including OTC medications):} \ \text{Lease attach the following information:} \ \text{Lorinoral Notes from most recent office visit.} \ \text{Lorinoral Notes from most from from from fine following reports:} \ \text{Lorinoral Notes from most from from fine following reports:} \ \text{Lorinoral Notes from most from fine following reports:} \ \text{Lorinoral Notes from most from fine following reports:} \ \text{Lorinoral Notes from most from fine following reports:} \ \text{Lorinoral Notes from most from fine following reports:} \ \text{Lorinoral Notes from fine following reports:} \ \text{Lorinoral Notes from fine following reports:} \ \text{Lorinoral Notes from fine following reports:} \ Lorinoral Notes from fin			irrhosis □Com	nnensated Cirrhosis			
Prior therapies and reasons for stopping (if applicable) Other medications patient is currently taking (including OTC medications): Commendation	·	•		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
Other medications patient is currently taking (including OTC medications): lease attach the following information: Clinical Notes from most recent office visit.	• • • • • • • • • • • • • • • • • • • •						
lease attach the following information: Colinical Notes from most recent office visit.	· · · · · · · · · · · · · · · · · · ·						
Clinical Notes from most recent office visit.			edications):				
Treatment readiness assessment (if applicable) Fibrosis Score - Attach one of the following reports: Imaging/Fibrosure/Fibroscan/Fibrometer/Hepascore Imaging/Fibroscan/Fibroscan/Fibroscan/Fibrometer/Hepascore Imaging/Fibroscan							
Fibrosis Score - Attach one of the following reports: Imaging/Fibrosure/Fibrosean/Fibrometer/Hepascore Imaging/Fibrosean/Fibrometer/Hepascore Imaging/Fibrosean/Fibrosean/Fibrometer/Hepascore Imaging/Fibrosean/Fi		ce visit.					
Imaging/Fibrosure/Fibroscan/Fibrometer/Hepascore Transplant status		(Drown in the neet 00 days)					
INSSA resistance-associated polymorphisms lab (if applicable)		. (Drawn in the past 90 days)					
PTNR - Prothrombin Time and International Normalize Ratio PRESCRIPTION INFORMATION		ornhisms lah (If annlicahle)			i ibi oi iletei/i lepascole		
PRESCRIPTION INFORMATION				- Transplant status			
Description		ornadorial Profitalizo Padio					
1 dablet PO once daily OR PEDIATRIC 17kg - 30kg: 200 mg/50 mg tablet 1 dablet PO once daily OR Other:							
1 tablet PO once daily OR Other:							
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3 tablets PO once daily with food QTY: 1 month Refills:	ŕ					QTT. THORA	11011110.
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Directions:	3 tablets PO once daily with food					QTY: 1 month	Refills:
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1 tablet PO once daily with food Carry 1 month Refills 1 month Refills 2 month 2 month Refills 2 month 2 month Refills 2 month 2	Wosevi (sofoshuvir/velnatasvir/vev	ilanrevir) 400 mg/100 mg/100 m	na tahlet				
DZepatier™ (elbasvir/grazoprevir) 50 mg/100 mg tablet 1 tablet PO once daily S5A resistance-associated polymorphisms: □None □M28 □Q30 □L31 □Y93 DOther: Intended combination therapy duration: □8 weeks □12 weeks □16 weeks □24 weeks □Other: I authorize Acaria-Health 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 and that my refuse to sign this authorization and that my refuse will not affect my ability to obtain		maprevii) 400 mg/100 mg/100 m	ing tablet			OTY: 1 month	Refills:
1 tablet PO once daily S5A resistance-associated polymorphisms: None M28 Q30 L31 QY93 1Other: Intended combination therapy duration: 8 weeks 12 weeks 16 weeks 24 weeks 0ther: 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. Lunderstand that I may revoke this authorization at and than my refuse to sign this authorization and that my refuse will not affect my ability to obtain	ŕ					QTT. THORAS	11011110
S5A resistance-associated polymorphisms: None M28 Q30 L31 QY93 Other:) mg/100 mg tablet				OTV 4	D. CII.
Other: Intended combination therapy duration:		iomo: □Nono □M20 □O20 □	JI 24 □V02			QTY: <u>1 month</u>	Retills:
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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 refuse to sign 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 refusel will not affect my ability to obtain	ntended combination therapy duration	on: □8 weeks □12 weeks	□16 weeks □	☐24 weeks ☐Other:			
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	regarding therapies. I understand that I may revoke this au	thorization at any time in writing by sending a letter	to AcariaHealth 6923 Le				

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. IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to AcariaHealth or any of its subsidiaries using the contact information provided on this coversheet.

Rev: 7.12.21