AcariaHealth™
Specialty Pharmacy

Phone: 800.511.5144 • Fax: 877.541.1503

Date Shipment Needed: _____ Ship To: ❑Patient ❑Prescriber
❑ Nursing needed; ❑Training needed ► All the supplies including syringes and needles will be dispensed if needed.

HEPATITIS C REFERRAL FORM

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ❑M ❑F	Weight: ❑lbs. ❑kg.
SSN:	Phone:	Allergies:		
Address:		City:	State:	Zip:
Emergency Contact:	Phone:	❑ **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

❑**Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

❑**Please check if enrolling in copay card** | **Copay ID:**

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Diagnosis Code: ❑ B18.2 ❑B18.1 ❑Other ICD 10 _____
❑Treatment naïve ❑Treatment experienced ❑Decompensated Cirrhosis ❑Compensated Cirrhosis

- If applicable: ❑Co-infected HIV/HCV ❑HBV/HCV
- Prior therapies and reasons for stopping (if applicable) _____
- Other medications patient is currently taking (including OTC medications):_____

Please attach the following information:

❑Clinical Notes from most recent office visit.	❑Viral Load – HCV-RNA (Drawn in the past 90 days)
❑Genotype – Copy of lab report.	❑Treatment readiness assessment (if applicable)
❑CBC / *including ALT, AST, SCr, etc.* (Drawn in the past 90 days)	❑Fibrosis Score – Attach one of the following reports:
❑Urine drug screen (If applicable)	Imaging/Fibrosure/Fibroscan/Fibrometer/Hepascore
❑NS5A resistance-associated polymorphisms lab (If applicable)	❑Transplant status
❑PT/NR – Prothrombin Time and International Normalize Ratio	

PRESCRIPTION INFORMATION

❑**Epclusa®** **OR** ❑ **generic sofosbuvir/velpatasvir (if available)**
❑**400 mg/100 mg tablet** **OR** **PEDIATRIC 17kg – 30kg:** ❑**200 mg/50 mg tablet**
1 tablet PO once daily **OR** Other:_____ QTY: 1 month Refills:____

❑**Harvoni®** **OR** ❑ generic **ledipasvir/sofosbuvir (if available)**
❑**90 mg/400 mg tablet** **OR** **PEDIATRIC <17kg:** ❑**33.75 mg/150 mg pellet | 17kg – 35kg:** ❑**45 mg/200 mg pellet** ❑**45 mg/200 mg tablet**
1 tablet/packet PO once daily **OR** Other:_____ QTY: 1 month Refills:____

❑**Sovaldi® (sofosbuvir) 400 mg tablet**
1 tablet PO once daily QTY: 1 month Refills:____

❑**Mavyret (glecaprevir and pibrentasvir) 100 mg/40 mg tablet**
3 tablets PO once daily with food QTY: 1 month Refills:____

❑**Ribavirin** ❑ 200 mg tablet ❑ 200 mg capsule
❑**Directions:** _____ QTY: 1 month Refills:____

❑**Vosevi (sofosbuvir/velpatasvir/voxilaprevir) 400 mg/100 mg/100 mg tablet**
1 tablet PO once daily with food QTY: 1 month Refills:____

❑**Zepatier™ (elbasvir/grazoprevir) 50 mg/100 mg tablet**
1 tablet PO once daily QTY: 1 month Refills:____
NS5A resistance-associated polymorphisms: ❑None ❑M28 ❑Q30 ❑L31 ❑Y93

❑**Other:** _____ QTY: _____ Refills:____
Intended combination therapy duration: ❑8 weeks ❑12 weeks ❑16 weeks ❑24 weeks ❑Other:_____

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: _____

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.