



866 413-3156 toll free phone
 877 834-1231 toll free fax
 QUESTIONS? Please Contact Us!
 www.REPharmacy.com

Hepatitis C/Hepatology Referral Form

Send your Rx to: _____ (optional)

Date Medication Needed: _____ Ship To: () Patient's Home () Prescriber's Office () Pick-Up (store location): _____ Injection training by pharmacy?

1) Patient & Insurance Information Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

Patient Name: _____ Birth Date: _____ Sex: () Male () Female Height: _____ Weight: _____ () lbs. () kgs.
 Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Insurance Info: _____ Policy Number: _____

2) Prescriber Information

Provider Name: _____ DEA #: _____ NPI #: _____ Tax ID#: _____
 Address: _____ Phone: _____ Fax: _____
 City, State, Zip: _____ Key Contact: _____ Phone: _____

3) Diagnosis/Clinical Information Please FAX recent clinical notes, labs and/or tests, with the prescription, to expedite the prior authorization.

<p>Diagnosis:</p> <input type="checkbox"/> B18.2 Hepatitis C <input type="checkbox"/> K72.9 Hepatic Encephalopathy <input type="checkbox"/> _____ <p>Genotype:</p> <input type="checkbox"/> 1a <input type="checkbox"/> 3 <input type="checkbox"/> 5 <input type="checkbox"/> 1b <input type="checkbox"/> 4 <input type="checkbox"/> 6 <input type="checkbox"/> 2	<p>For XIFAXAN:</p> <p>Prior drug tried & failed:</p> <input type="checkbox"/> Cipro <input type="checkbox"/> Neomycin <input type="checkbox"/> Flagyl <input type="checkbox"/> Lactulose <input type="checkbox"/> Tetracycline <input type="checkbox"/> _____ <p>Does patient have Cirrhosis? () Yes () No Fibrosis Score: _____ Date: _____</p>	<p>For Hepatitis:</p> <p>Most recent lab date: <input type="checkbox"/> Naive patient <input type="checkbox"/> Non-responder* <input type="checkbox"/> Relapser* *Initial therapy Start Date: _____ Length: _____</p> <p>AST: _____ ALT: _____ HCV RNA: _____ (viral load) Does patient need nurse training? () Yes () No</p>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

4) Prescription Information

VOSEVI® (sofosbuvir 400mg, velpatasvir 100mg, and voxilaprevir 100mg) Disp#28 Sig: one daily Refill: _____ Duration of therapy: _____ weeks

ZEPATIER® (50mg elbasvir/100mg grazoprevir) Disp#28 Sig: one daily Refill: _____ Duration of therapy: _____ weeks

HARVONI® (90mg ledipasvir/400mg sofosbuvir) Disp#28 Sig: one daily Refill: _____ Duration of therapy: _____ weeks

EPLCUSA® (sofosbuvir 400mg and velpatasvir 100mg) Refill: _____ Duration of therapy: _____ weeks
 Sig: One daily [patients without cirrhosis or with compensated cirrhosis (Child-Pugh class A)].
 Sig: One daily in combination with ribavirin [patients with decompensated cirrhosis (Child-Pugh class B or C)].

VIEKIRA PAK® Disp#28 Refill: _____ Duration of therapy: _____ weeks
 Sig: Take 2 ombitasvir, paritaprevir, ritonavir 12.5/75mg/50mg QAM, and 1 dasabuvir 250mg bid with meal.

VIEKIRA XR® 200mg 8.33mg 50mg 33.33mg (Tablet extended-release 24 Hour). Disp#84
 Sig: Extended-release: 3 tablets once a day.

RIBAVIRIN Disp#28 Refill: _____ Duration of therapy: _____ weeks
 Sig: 1200mg daily/600mg QAM — 600mg QPM < 75kg = 1000mg/day ≥ 75kg = 1200mg/day
 Sig: 1000mg daily/600mg QAM — 400mg QPM

SOVALDI® (sofosbuvir) 400mg Disp#28 Sig: one daily Refill: _____ Duration of therapy: _____ weeks

OLYSIO® (simeprevir) 150mg Disp#28 Sig: one daily Refill: _____ Duration of therapy: _____ weeks

DAKLINZA (daclatasvir) 30mg 60mg Disp#28 Sig: one daily Refill: _____ Duration of therapy: _____ weeks

TECHNIVIE® (12.5mg ombitasvir/75mg paritaprevir/50mg ritonavir) Disp#28 Sig: two daily Refill: _____ Duration of therapy: _____ weeks

PEGASYS®:

MAVYRET®
 Sig: 3 tablets once daily for 8 weeks (without cirrhosis) or 12 weeks (with compensated cirrhosis) [Child-Pugh A].
 Genotype 1: Prior treatment with an NS5A inhibitor containing regimen without an NS3/4A PI: 3 tablets once daily for 16 weeks.
 Genotype 1: Prior treatment with an NS3/4A PI: 3 tablets once daily for 12 weeks.

PROMACTA® _____ mg Disp#30 Sig: one daily Refill: _____ Duration of therapy: _____ weeks

Other:

5) Prescriber Signature Prescriber, please sign and date below.

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Dispense as written _____ Date _____ Substitution Permissible _____ Date _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. In no event should such material be read or retained by anyone other than the named addressee, except by express authorization of the sender to the named addressee. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

#of Prescriptions