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Hepatitis C Referral Form

Ship to: Patient Prescriber Pick Up (location): _____ Date Needed: _____ Need Nurse Need Training

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI#: _____ DEA#: _____
City: _____ State: _____ Zip: _____	Address: _____
Phone: () _____ Alt Phone: () _____	City: _____ State: _____ Zip: _____
Patient Soc. Sec#: _____ Date of Birth: / /	Phone: () _____ Fax: () _____
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Weight _____ lbs/kg Height _____	Nurse/Key Office Contact: _____
Allergies: _____	

CLINICAL INFORMATION (Please FAX recent clinical notes, labs, tests & current medication list with prescription)

<p>Diagnosis <input type="checkbox"/> B18.2 Hepatitis C (Chronic) <input type="checkbox"/> Other ICD-10 _____ Genotype: _____ Pre-treatment Viral Load: _____ Collection Date: _____ Co-infected with: <input type="checkbox"/> HIV <input type="checkbox"/> HepB <input type="checkbox"/> N/A Cirrhosis <input type="checkbox"/> Compensated <input type="checkbox"/> Decompensated <input type="checkbox"/> Hepatocellular carcinoma <input type="checkbox"/> Post Liver Transplant Patient's Grade/Child-Pugh score: _____ Fibroscan™? <input type="checkbox"/> Yes <input type="checkbox"/> No Results: _____ kPa History of liver biopsy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A History of liver test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Fibrosis present? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> F3 <input type="checkbox"/> F4 Fibro score: _____ <input type="checkbox"/> N/A</p>	<p>Prior Treatment Has the patient been previously treated for Hepatitis C? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name the product(s), date range(s) and response/outcome (none, partial, full remission, recurrence/relapse). Product: _____ Date Range: _____ to _____ Response/outcome: _____ Product: _____ Date Range: _____ to _____ Response/outcome: _____ Does patient have any contraindications or intolerances to any Hepatitis C medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please name medication and describe reaction? _____ Labs: to be performed prior to therapy and monitored during treatment at appropriate intervals ALT: _____ Date: _____ AST: _____ Date: _____ Hgb _____ Date: _____ Platelet: _____ Date: _____ Albumin _____ Date: _____ Serum creatinine: _____ Date: _____ Pregnancy (if appropriate): _____ Date: _____ NS5A resistant polymorphisms? <input type="checkbox"/> Yes <input type="checkbox"/> No NS5A polymorphism type: <input type="checkbox"/> M28 <input type="checkbox"/> Q30 <input type="checkbox"/> L31 <input type="checkbox"/> Y93 Q80K polymorphism: <input type="checkbox"/> Yes <input type="checkbox"/> No IL28B polymorphism: <input type="checkbox"/> Yes <input type="checkbox"/> No Other disease states: Depression: _____ Anxiety _____ Diabetes: _____ Other medications (including OTC): please attach list if necessary _____</p>
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PRESCRIPTION INFORMATION

DRUG	DOSE	DIRECTIONS	QUANTITY	REFILLS
Daklinza® (daclatasvir)	<input type="checkbox"/> 60mg tablet <input type="checkbox"/> 30mg tablet	<input type="checkbox"/> Take one tablet PO once daily with Sovaldi Duration: <input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks <input type="checkbox"/> Other _____	28 tablets	
Epclusa® (sofosbuvir/velpatasvir)	<input type="checkbox"/> 400mg/100mg tablet	<input type="checkbox"/> Take one tablet PO once daily Duration: <input type="checkbox"/> 12 weeks <input type="checkbox"/> Other _____	28 tablets	
Harvoni® (ledipasvir/sofosbuvir)	<input type="checkbox"/> 90mg/400mg tablet	<input type="checkbox"/> Take one tablet PO once daily <input type="checkbox"/> Other: _____ Duration: <input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks <input type="checkbox"/> _____	28 tablets	
Mavyret™ (glecaprevir/pibrentasvir)	<input type="checkbox"/> 100mg/40mg tablet	<input type="checkbox"/> Take 3 tablets PO once daily with food. Duration: <input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> 16 weeks	84 tablets	
Olysio® (simeprevir)	<input type="checkbox"/> 150mg capsule	<input type="checkbox"/> Take one tablet PO once daily with food Duration: <input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks	28 tablets	
Sovaldi® (sofosbuvir)	<input type="checkbox"/> 400mg tablet	<input type="checkbox"/> Take one tablet PO once daily <input type="checkbox"/> Other: _____ Duration: <input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks <input type="checkbox"/> _____	28 tablets	
Technivie™ (ombitasvir, paritaprevir, ritonavir)	<input type="checkbox"/> 12.5/75/50mg tablet	<input type="checkbox"/> Take 2 tablets PO every morning with food Duration: <input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks <input type="checkbox"/> Other _____	56 tablets	
Viekira Pak® (dasabuvir/ombitasvir/paritaprevir/ritonavir)	<input type="checkbox"/> 250/12.5/75/50mg tablet	<input type="checkbox"/> Take 3 tablets PO in the morning and 1 tablet PO in the evening with food. Duration: <input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks <input type="checkbox"/> Other _____	112 tablets	
Viekira XR™ (dasabuvir/ombitasvir/paritaprevir/ritonavir)	<input type="checkbox"/> 200/8.33/50/33.33mg tablet	<input type="checkbox"/> Take 3 tablets PO once daily with food. Duration: <input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks <input type="checkbox"/> Other _____	84 tablets	
Vosevi™ (sofosbuvir/velpatasvir/voxilaprevir)	<input type="checkbox"/> 400mg/100mg/100mg tablet	<input type="checkbox"/> Take one tablet PO once daily with food. Duration: <input type="checkbox"/> 12 weeks	28 tablets	
Zepatier™ (elbasvir/grazoprevir)	<input type="checkbox"/> 50mg /100mg tablet	<input type="checkbox"/> Take one tablet PO once daily <input type="checkbox"/> Other: _____ Duration: <input type="checkbox"/> 12 weeks <input type="checkbox"/> 16 weeks <input type="checkbox"/> Other _____	28 tablets	
Riba-Pak® (ribavirin)	<input type="checkbox"/> 600mg/day (200mg/400mg) <input type="checkbox"/> 800mg/day (400mg/400mg) <input type="checkbox"/> 1000mg/day (600mg/400mg) <input type="checkbox"/> 1200mg/day (600mg/600mg)	<input type="checkbox"/> Take 200mg tablet PO QAM & 400mg tablet QPM=600mg/day <input type="checkbox"/> Take 400mg tablet PO QAM & 400mg tablet QPM=800mg/day <input type="checkbox"/> Take 600mg tablet PO QAM & 400mg tablet QPM=1000mg/day <input type="checkbox"/> Take 600mg tablet PO QAM & 600mg tablet QPM=1200mg/day	<input type="checkbox"/> 1-month <input type="checkbox"/> 3-month	
Ribavirin	<input type="checkbox"/> 200mg tablet <input type="checkbox"/> 200mg capsule	<input type="checkbox"/> Take _____ tabs/caps OAM & _____ tabs/caps QPM with food. <input type="checkbox"/> Other: _____	Qty: _____	
Pegasys® (peginterferon alfa-2a) injection	<input type="checkbox"/> 135mcg/0.5mL ProClick™ <input type="checkbox"/> 180mcg/0.5mL ProClick™ <input type="checkbox"/> 180mcg/0.5mL PFS kit of 4	<input type="checkbox"/> Inject 135mcg SC once weekly <input type="checkbox"/> Inject 180mcg SC once weekly <input type="checkbox"/> Other: _____	4 doses	
Other	<input type="checkbox"/> _____	<input type="checkbox"/> _____		

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARDS (FRONT & BACK)

To Prescriber: By signing this form and utilizing our services, you are authorizing Infinity Care Solutions, a division of Infinity Compounding Solutions, LLC, its agents and employees, to serve as your prior authorization designated agent in dealing with medical or prescription claims payers, processors and other entities.

Date: _____

DISPENSE AS WRITTEN

MAY SUBSTITUTE