Hepatitis C Referral Form

Phone: 1.877.592.7988
Fax: 1.800.787.0874

Rosemont Specialty Pharmacy
www.rosemontspecialtyrx.com

Date Medication Needed: _____ **Ship To:** ○ Patient's Home ○ Prescriber's Office ○ Pick-up

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: ○ Male ○ Female Height: _____ Weight: _____ ○ lbs. ○ kg.

Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____

Address: _____ City: _____ State: _____ Zip: _____

Alternate Caregiver Name: _____ Preferred Phone: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

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, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis/ICD-10: _____ Genotype: ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Viral Load: _____ Date: _____

Fibrosis Score: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4 Cirrhosis: ☐ None ☐ Compensated ☐ Decompensated Child-Pugh: ☐ A ☐ B ☐ C

IL-28: ☐ CC ☐ CT ☐ TT NS5A Polymorphism: ☐ Y ☐ N NS5A Polymorphism Type: ☐ 28 ☐ 30 ☐ 31 ☐ 93 ☐ Other_____ HIV Co-infection ☐ HBV Co-infection ☐

Prior Therapy	End Date	Treatment Weeks	Response Status
			☐ Naive ☐ Null ☐ Partial ☐ Relapse
			☐ Naive ☐ Null ☐ Partial ☐ Relapse

4: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Daklinza®** (daclatasvir)	☐ 60mg ☐ 30mg	Take 1 tablet by mouth daily, with or without food in combination with sofosbuvir	28 day supply	
☐ **Epclusa®** (sofosbuvir/velpatasvir)	☐ 400mg/100mg	Take 1 tablet by mouth daily, with or without food	28 day supply	
☐ **Harvoni®** (ledipasvir/sofosbuvir)	☐ 90mg/400mg	Take 1 tablet by mouth daily, with or without food	28 day supply	
☐ **Mavyret™** (glecaprevir/pibrentasvir)	☐ 100mg/40mg	Take three tablets once daily with food	28 day supply	
☐ **Olysio®**	☐ 150mg	Take 1 capsule by mouth daily with food *(Olysio is FDA approved for use with ribavirin and pegylated interferon, also approved in combination with Sovaldi)*	28 day supply	2
☐ **Pegasys®** ☐ Prefilled Syringe ☐ Vial ☐ ProClick®	☐ 180mcg ☐ 135mcg	☐ 180 mcg SQ once weekly ☐ 90 mcg SQ once weekly ☐ 135 mcg SQ once weekly	28 day supply	
☐ **RibaPak®** ☐ **Moderiba®**	☐ 600mg ☐ 800mg ☐ 1000mg ☐ 1200mg	☐ 200mg every morning, 400mg every evening ☐ 400mg every morning, 400mg every evening ☐ 600mg every morning, 400mg every evening ☐ 600mg every morning, 600mg every evening	28 day supply	
☐ **RibaSphere®** (generic ribavirin)	☐ 200mg			
☐ **Sovaldi®**	☐ 400mg	Take 1 tablet by mouth daily, with or without food	28 day supply	
☐ **Technivie™** (ombitasvir, paritaprevir and ritonavir tablets)	☐ 12.5mg/75mg/50mg	Take 2 ombitasivir, paritaprevir, ritonavir tablets by mouth once daily in the morning with a meal without regard to fat or calorie content *(Technivie is FDA approved for use with ribavirin)*	28 day supply	
☐ **Viekira Pak™** (ombitasvir, paritaprevir and ritonavir tablets copackaged with dasabuvir tablets)	☐ 2.5mg/75mg/ 50mg/250mg	Take 2 ombitasvir, paritaprevir, ritonavir (pink tablets) once daily (in the morning) and 1 dasabuvir (beige tablet) twice daily (morning and evening) with a meal without regard to fat or calorie content	28 day supply	
☐ **Viekira XR™** (coformulated tablet contains dasabuvir,ombitasvir, paritaprevir, and ritonavir)	☐ 200mg/8.33mg/ 50mg/33.33mg	Take 3 tablets, 1 pack, daily with a meal without regard to fat or calorie content	28 day supply	
☐ **Vosevi™** (sofosbuvir/velpatasvir/ voxilaprevir)	☐ 400mg/100mg/100mg	Take 1 tablet by mouth daily with food	28 day supply	
☐ **Zepatier™** (elbasvir/grazoprevir)	☐ 50mg/100mg	Take 1 tablet by mouth daily, with or without food	28 day supply	
☐				

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: _____ Date: _____

Prescriber Signature: Prescriber, please sign and date below

Dispense as written Date Substitution Permissable Date

# of Prescriptions: _____