Hepatitis C
Prescription Referral Form
ESCRIBE #: 5700174
Phone: 1.877.592.7988
Fax: 1.800.787.0874

Rosemont Specialty Pharmacy

www.rosemontspecialtyrx.com

1. Patient Information

Patient Name: | SSN: | DOB:

Address: | City: | State: | Zip:

Home Phone: | Cell Phone: | Email Address:

Sex: ☐Male ☐Female | Height: | Weight: ☐ lbs. ☐ kg. | Known Allergies:

2. Insurance Information:

Please fax front and back copy of all Insurance cards (Prescription and Medical)

3. Prescription Information: For IV medications attach a copy of your prescription

To prevent generic substitution, Prescriber to handwrite “Brand Medically Necessary” and sign:

Clinical information:

Responder status:
❑ Treatment Naïve
❑ Treatment Experienced

Prior Treatment:
Type: ________________________

Did patient fail NS5A based treatment (Harvoni, Daklinza, Viekira, Zepatier)?
❑ No ❑ Yes (Please include RAV)

Comorbidities:
❑ ESRD
❑ HIV
❑ HBV
❑ Diabetes
❑ Other _____________________

Fibrosis Stage: ________________

Child-Pugh Score: ______________

HCV genotype:
❑ 1 ❑ 1a ❑ 1b
❑ 2 ❑ 2a ❑ 2b
❑ 3 ❑ 3a ❑ 3b
❑ 4 ❑ 4a ❑ 4b
❑ Other _____________________

HCV RNA: ___________________

Cirrhosis: ❑ Y ❑ N
If YES: ❑ Compensated
❑ Decompensated

Medications

☐ EPCLUSA® (Sofosbuvir 400mg/Velpatasvir 100mg)
Take 1 tablet by mouth daily, with or without food.
Qty: 28 Day Supply Refills:

☐ HARVONI ® (ledipasvir 90mg/sofosbuvir 400mg)
One tablet taken by mouth once daily.
Qty: 28 Day Supply Refills:

☐ SOVALDI™ (sofosbuvir)
Take 1 tablet by mouth daily, with or without food.
Qty: 28 Day Supply Refills:

☐ DAKLINZA™ (daclatasvir) ☐ 60mg ☐ 30mg
Take 1 tablet by mouth daily, with or without food in combination with Sofosbuvir and ribavirin (600mg orally once daily).
Qty: 28 Day Supply Refills:

☐ OLYSIO® (Simeprevir)
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).
Qty: 28 Day Supply Refills:

☐ RIBAVIRIN® 200mg
______ mg every morning ______ mg every evening
Qty: 28 Day Supply Refills:

☐ VIEKIRA PAK™ (ombitasvir/paritaprevir/ritonavir tablets Co-packaged with dasabuvir tablets)
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.
Qty: 28 Day Supply Refills:

☐ VOSEVI™ (Sofosbuvir 400mg/Velpatasvir 100mg/Voxilaprevir 100mg)
Take 1 tablet by mouth daily with food
Qty: 28 Day Supply Refills:

☐ ZEPATIER® (elbasvir 50mg/grazoprevir 100mg)
Take 1 tablet by mouth daily, with or without food
Qty: 28 Day Supply Refills:

☐ Sofosbuvir 400mg/Velpatasvir 100mg
Take 1 tablet by mouth daily, with or without food.
Qty: 28 Day Supply Refills:

☐ Ledipasvir 90mg/sofosbuvir 400mg
One tablet taken by mouth once daily.
Qty: 28 Day Supply Refills:

☐ Sofosbuvir
Take 1 tablet by mouth daily, with or without food.
Qty: 28 Day Supply Refills:

☐ MAVYRET™ (glecaprevir/pibrentasvir)
Three tablets (total daily dose: glecaprevir 300mg and pibrentasvir 120mg) taken orally once daily with food.
Qty: 28 Day Supply Refills:

☐ PEGASYS® (Peginterferon alfa-2a) ☐ 90mcg ☐ 135mcg ☐ 180mcg
Inject ____ mcg under the skin once weekly
Qty: 28 Day Supply Refills:

☐ TECHNIVIE™ (ombitasvir/paritaprevir/ritonavir tablets)
Take 2 ombitasivir/paritaprevir/ritonavir tablets by mouth once daily with a meal without regard to fat or calorie content (Technivie is FDA approved for use with ribavirin).
Qty: 28 Day Supply Refills:

☐ VIEKIRA XR™ (Coformulated: Dasabuvir/ombitasvir/paritaprevir/ritonavir)
Take 3 tablets daily with a meal without regard to fat or calorie Content
Qty: 28 Day Supply Refills:

☐ OTHER
STREGNTH:
SIG/DIRECTIONS:

4. Physician Information:

Prescriber Name: | Prescriber NPI: | DEA#:

Address: | City: | State: | Zip:

Primary Office Contact: | Fax Number: | Phone Number:

Office Contact Email:

Prescriber Signature: Prescriber, please sign and date below

*I authorize Rosemont Specialty Pharmacy and it’s representatives to act as my authorized agent to secure coverage and initaite prior authorization process for my patient(s), and to sign any necessary forms on my behalf as authorized agents, including the recipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fullfill this prescription, I further authorize to forward this information and any related to coverage of the product to another pharmacy of patient’s choice or in the patient’s insurer’s provider network.

☐ Dispense as written ☐ Substitution Permissible

Prescriber’s Signature ________________________________ Date ______________

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This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.