HEPATITIS C PRESCRIPTION REFERRAL FORM

LifeCare Specialty Pharmacy

Send your Rx to: **Fax: 702-697-2107**

Phone: 702-697-2105

Date Medication Needed: _____ ☐ **First shipment only to MDO** ☐ All shipments to MDO ☐ All shipments to patient

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)

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

HIV Co-infection ☐ **HBV Co-infection** ☐

Patient treatment history – Response Status: ☐ Naive ☐Null ☐Partial ☐Relapse

End date of previous therapy or medications: _____ **Medication taken:** _____

Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **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	
☐ **RibaPak®**	☐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	
☐ **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	
☐ **Ribavirin®**	☐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	
☐ **Sovaldi®**	☐400mg	Take 1 tablet by mouth daily, with or without food	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	

Prescriber Information

Provider Name: _____ **DEA#:** _____ **NPI#:** _____ **Tax ID#:** _____

Address: _____ **Phone:** _____ **Fax:** _____

City, State, Zip: _____ **Key Contact:** _____ **Phone:** _____

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

I authorize LifeCare Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

# of Prescriptions: _____