Hepatitis C Referral Form

Fax: 844-635-5250

Patient Information

Patient Name: _____ Date:_____ DOB: _____ SS#: _____

Ship To Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Alternate Phone: _____

Medical Assessment

Diagnosis: B18.2 – Chronic HCV **Allergies**: _____ Initial Viral Load/Date: _____ M copies/ml _____

Genotype: _____ Metavir Fibrosis Score _____ Test Type: _____ Naïve ___ Relapser ___ Non Responder ___

Prior Treatments Used: _____ When: _____ Cirrhosis? Yes__ No__ Compensated __ Decompensated __

HIV Co-Infected: Yes __ No __ HBV Co-Infection Yes __ No __ Drug / Alcohol Screen Included? Yes__ No__

Medication

Epclusa (sofosbuvir 400 / velpatasvir 100mg)
_____ Sig: 1 tablet PO once daily **Qty: 28 day supply** **Refills x _____ Months**

Viekira PAK (Paritaprevir 75 / Ritonavir 50 – Ombitasvir 12.5 & Dasabuvir 250mg)
_____ Sig: Take as directed by mouth on PAK **Qty: 28 day supply** **Refills x _____ Months**

Viekira XR (dasabuvir, ombitasvir, paritaprevir, & ritonavir)
_____ Sig: Take 3 tablets once daily with a meal **Qty: 28 day supply** **Refills x _____ Months**

Harvoni 90mg / 400mg (Ledipasvir / Sofosbuvir)
_____ Sig: 1 tablet PO once daily **Qty: 28 day supply** **Refills x _____ Months**

Sovaldi (Sofosbuvir) 400mg
_____ Sig: 1 tablet PO once daily **Qty: 28 day supply** **Refills x _____ Months**

Zepatier 50 / 100mg (elbasvir / grazoprevir)
_____ Sig: 1 tablet PO once daily **Qty: 28 day supply** **Refills x _____ Months**

Daklinza (Daclatasvir) ___ 60 mg ___ 30 mg **Qty: 28 day supply** **Refill x _____ Months**
_____ Sig: 1 tablet PO once daily

Technivie (Ombitasvir 12.5 mg / Paritaprevir 75 mg/ Ritonavir 50 mg)
_____ Sig: 2 tablets PO once daily (in the morning) with a meal **Qty: 28 day supply** **Refills x _____ Months**

Vosevi (sofosbuvir 400mg / velpatasvir 100mg / voxilaprevir 100mg)
_____ Sig: 1 tablet PO once daily with food **Qty: 28 day supply** **Refills x _____ Months**

Mavyret (glecaprevir / pibrentasvir)
_____ Sig: take 3 tablets PO once daily with food **Qty: 28 day supply** **Refills x _____ Months**

Ribapak

- ❑ 600 mg AM and 600mg PM (1200 mg)
- ❑ 600 mg AM and 400 mg PM (1000 mg)
- ❑ 400 mg AM and 400 mg PM (800 mg)
- ❑ 200 mg AM and 400 mg PM (600mg)

Qty: 28 day supply **Refills: _____ Months**

Ribavirin 200 mg

- ❑ 800 mg/day
- ❑ 1000 mg / day
- ❑ 1200 mg/day

Qty: 28 day supply **Refills x _____ Months**

Physician Prescription Orders

Physician Name: _____ NPI #: _____ Phone: _____ Fax: _____

Address: _____ Date: _____ Nurse: _____

Physician Signature: _____