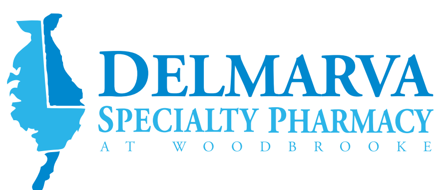

HEPATITIS C REFERRAL FORM

1615 Tree Sap Court Salisbury, MD 21804
Tel 410.677.0561 Fax 410.677.0562

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Oct 2017

Patient Name ______ First Name ______ Middle Name ______ Last Name ______ DOB ______ Weight ______ ☐ Male ☐ Female
Street Address ______ Apt # ______ City ______ State ______ Zip ______
Daytime Tel ______ Evening Tel ______ Cell ______ Email ______
Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed ______
ICD-10 Diagnosis ______ Biopsy ☐ Yes ☐ No Results ______ Previously Treated ☐ Yes ☐ No If yes, what drugs ______
HCV MEDICAL CRITERIA Genotype ______ HCV-Viral Load ______ (IU) Date of Labs ______ ALT ______ AST ______ Hgb ______

Insured's Name ______ Relation to Patient ______ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# ______
Prescription Card ☐ Yes ☐ No If Yes, Carrier ______ Tel ______ Fax ______ Policy/Group# ______
Bin# ______ Pcn# ______ RXID# ______ RX Group# ______

Prescriber's Name ______ Office Contact ______
Street Address ______ Suite # ______ City ______ State ______ Zip ______
Tel ______ Fax ______ Email ______
License# ______ NPI# ______ UPIN# ______ DEA# ______

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

MAVYRET
☐ 100 mg glecaprevir/40 mg pibrentasvir tablet
SIG: ☐ Take 3 tablets PO once daily with food QTY:____ Refill:_____
☐ Other:______ QTY:____ Refill:_____

VOSEVI
☐ 400 mg sofosbuvir/100 mg velpatasvir/100 mg voxilaprevir tablet
SIG: ☐ Take 1 tablet PO daily w/ food for 12 wks QTY:____ Refill:_____
☐ Other:______ QTY:____ Refill:_____

PEG INTRON
☐ REDIPEN ☐ VIAL
Strength (Dose) ☐ 50mcg/0.5ml ☐ 80mcg/0.5ml
☐ 120mcg/0.5ml ☐ 150mcg/0.5m
Directions ______
Quantity: ☐ 1 month ☐ 3 months Refill x ______

PEGASYS
☐ **ProClick** 135mcg Autoinjector (NDC 004-0365-30) Inject SQ weekly
☐ **ProClick** 180mcg Autoinjector (NDC 004-0365-30) Inject SQ weekly
☐ **Pre-Filled Syringe** 180mcg/0.5ml (NDC 004-0357-30) Inject SQ weekly
☐ Other ______
Quantity: ☐ 1 month ☐ 3 month Refill x ______

INFERGEN
☐ 9mcg TIW for ______ Weeks ☐ 9mcg QD
☐ 15mcg TIW for ______ Weeks ☐ 12mcg QD
☐ Other:______ Refill x ______ Months

DAKLINZA
GT3 ONLY
☐ 30 mg / ☐ 400 mg SOVALDI Qty:28 Refills: ______
☐ 60 mg / ☐ 400 mg SOVALDI Qty:28 Refills: ______
SIG: take 1 tablet each daily Total daily dose:______

☐ TECHNIVIE
paritaprevir/ritonavir (75/50 mg) and ombitasvir (12.5 mg)
SIG: two tablets QAM with meal and with ☐ RIBAVIRIN
Qty:_____ Refill:_____ GT4 ONLY

RIBAVIRIN® | RIBAPAK
☐ Ribapak 600mg PO Daily; 200mg QAM, 400mg QPM
☐ Ribapak 800mg PO Daily; 400mg QAM, 400mg QPM
☐ Ribapak 1000mg PO Daily; 600mg QAM, 400mg QPM
☐ Ribapak 1200mg PO Daily; 600mg QAM, 600mg QPM
☐ Ribavirin 200mg Sig ______
Quantity ______ Refill x ______

SOVALDI
(Sofosbuvir) 400mg tablet
SIG: Take 1 tablet by mouth daily for:
☐ 12 weeks w/ Ribavirin and peginterferon (Genotype 1 or 4)
☐ 12 weeks with Ribavirin (Genotype 2)
☐ 24 weeks with Ribavirin (Genotype 3)
Quantity ______ Refill x ______

EPCLUSA
☐ Sofosbuvir 400 mg/Velpatasvir 100 mg tablet
SIG: ☐ Take1 tablet once a day for 12 weeks
QTY:____ Refill:_____
☐ 1 tab 1x day for 12 weeks WITH ribavirin
QTY:____ Refill:_____

OLYSIO
(Simeprevir) ☐ 150mg capsule
SIG: Take 1 capsule by mouth daily for 12 wks w/peginterferon and ribavirin
Qty:____ Refill x____

VICTRELIS
☐ 800mg(4 x 200mg) P.O. Tid w/food
Refill x ______ Months Sig ______

☐ HARVONI
Ledipasvir 90mg / Sofosbuvir 400mg
SIG: Take 1 tablet by mouth daily
QTY 28 Refills ______

HEPATITIS B ORAL THERAPIES
☐ Baraclude
☐ 0.5mg ☐ 1.0mg
☐ Epivir HBV 100mg
☐ Hepsara 10mg
☐ Tyzeka 600mg

☐ 1 Tablet po QD
Additional Directions: ______
Quantity
☐ 1 Month ☐ 3 Month

By signing this form and utilizing our services, you are authorizing Delmarva Specialty and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) ______ **Date** ______

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