

# HEPATITIS C Prescription Referral Form

Phone: 843-352-7662 | Fax: 833-898-3992 | Backup Fax 843-352-7632 | 1501 Belle Isle Ave #150 Mt Pleasant SC 29464

## PATIENT INFORMATION - PLEASE FORWARD FRONT AND BACK OF INSURANCE CARDS

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  M  F  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ SSN: \_\_\_\_\_ Patient Preferred Language:  English  Spanish  \_\_\_\_\_

## PRESCRIBER INFORMATION

Name: \_\_\_\_\_ DEA: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Contact Person: \_\_\_\_\_  
 Office's Preferred Method of Contact:  Phone  Fax  Portal  Email: \_\_\_\_\_  Other: \_\_\_\_\_

## PATIENT CLINICAL INFORMATION / HISTORY -PLEASE FORWARD ALL CHART NOTES AND LABWORK

Diagnosis: Hepatitis C ICD 10: B18.2 Genotype:  1a  1b  2  3  4 Viral Load: \_\_\_\_\_  
 Responder Status:  Naive  Null  Partial  Relapse | Severe Renal Impairment:  Yes  No  
 Fibrosis Score: \_\_\_\_\_ Cirrhosis:  Yes  No  Compensated  Decompensated  
 Previous / Failed Medications: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## ADDITIONAL DOCUMENTATION TO SEND

<input type="checkbox"/> Viral Load	<input type="checkbox"/> Genotype Lab	<input type="checkbox"/> CMP	<input type="checkbox"/> Liver Staging Documentation	<input type="checkbox"/> NHBV Surface + Core Antibodies
<input type="checkbox"/> CBC	<input type="checkbox"/> Resistance Testing	<input type="checkbox"/> Chart Notes	<input type="checkbox"/> Patient's Insurance Card	<input type="checkbox"/> Commitment Letter

## PRESCRIBING INFORMATION

NEW  RESTART  CONTINUING | SHIPPING PREFERENCE:  Deliver Medication to Patient  Deliver Medication to MDO  
 First Fills  All Fills

MEDICATION	DOSAGE	SIG	QTY	RFLS
<input type="checkbox"/> EPCLUSA	<input type="checkbox"/> 400mg/100mg	<input type="checkbox"/> Take 1 tablet by mouth once daily with or without food		
<input type="checkbox"/> HARVONI	<input type="checkbox"/> 90mg/400mg	<input type="checkbox"/> Take 1 tablet by mouth once daily with or without food		
<input type="checkbox"/> MAVYRET	<input type="checkbox"/> 100mg/40mg	<input type="checkbox"/> Take 3 tablets by mouth once daily with food		
<input type="checkbox"/> RIBAVIRIN	<input type="checkbox"/> 200mg	<input type="checkbox"/> Take _____ by mouth every morning and take _____ by mouth every evening		
<input type="checkbox"/> VOSEVI	<input type="checkbox"/> 400mg/100mg/100mg	<input type="checkbox"/> Take 1 tablet by mouth once daily with food		

## PRESCRIPTION SIGNATURE

Dispense as Written: \_\_\_\_\_ Substitution Permitted: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize Blue Sky Specialty Pharmacy and it's representatives to act as my agent in order to initiate and execute the insurance prior authorization process / appeals if necessary, in doing so, to release clinical information via phone / fax to appropriate third party payer