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

Prescriber Name: _____ DEA: _____ NPI: _____

Address: _____

Phone Number: _____ Fax Number: _____ Contact Person: _____

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: ☐Naïve ☐Null ☐Partial ☐Relapse | Severe Renal Impairment: ☐Yes ☐No

Fibrosis Score: _____ Cirrhosis: ☐Yes ☐No ☐ Compensated ☐ Decompensated

Previous / Failed Medications: _____

_____

_____

_____

PRESCRIBING INFORMATION

☐ NEW ☐ RESTART ☐ CONTINUING | SHIPPING PREFERENCE: ☐ Deliver medication to patient ☐ Deliver medication to MD

☐ First Fill ☐ All Fills

MEDICATION	DOSAGE	SIG	QTY	REFILLS
☐ EPCLUSA	☐ 400mg/100mg	☐ Take 1 tablet by mouth once daily with or without food		
☐ HARVONI	☐ 90mg/400mg	☐ Take 1 tablet by mouth once daily with or without food		
☐ MAVYRET	☐ 100mg/40mg	☐ Take 3 tablets by mouth once daily with food		
☐ RIBAVIRIN	☐ 200mg	☐ Take _____ by mouth every morning and take _____ by mouth every evening		
☐ VOSEVI	☐ 400mg/100mg/100mg	☐ 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 payor.