

Hepatitis C Prescription Referral Form



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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: _____
 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: Naïve 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 (if applicable)	<input type="checkbox"/> Chart Notes	<input type="checkbox"/> Patient's Insurance Card	<input type="checkbox"/> Commitment Letter (if applicable)

PRESCRIBING INFORMATION

NEW RESTART CONTINUING | SHIPPING PREFERENCE: Deliver medication to patient Deliver medication to MD
 First Fill All Fills

MEDICATION	DOSAGE	SIG	QTY	REFILLS
<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 payor.