

Hepatitis C

Prescription Referral Form



Phone: 843.352.7662 | Fax 833.898.3992 | Backup Fax 843.352.7632 | 570 Long Point Rd Ste 170 Mt. Pleasant SC 29464

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Race: _____ M F
 Street Address: _____ City: _____ State: _____ Zip: _____
 Cell Phone: _____ SSN: _____ **(PLEASE FORWARD FRONT AND BACK OF INSURANCE CARDS)**

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____
 Address: _____
 Phone Number: _____ Fax Number: _____ Contact Person: _____

PATIENT CLINICAL INFORMATION / HISTORY

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: _____

(PLEASE FORWARD ALL CHART NOTES AND LABWORK)

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		
<input type="checkbox"/> OTHER	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____		

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.

Important Notice: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you have received this communication and you are not the intended recipient, you should not disseminate, distribute, or copy this fax. Please notify sender immediately if you have received in error and then destroy this document immediately.