RICHMOND PHARMACY
Specialty Script

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HEPATITIS C REFERRAL FORM

Date: ____/____/____ Needs by Date: ________

Language: ____________ ☐ Nursing Instruction Required

Ship to: ☐ Patient ☐ MD Office

Prescriber's Name: ____________ DEA #: ________ NPI: ________

Address: ____________ City, State, Zip: ____________

Phone: ________ Fax: ________ Office Contact: ________

PATIENT INFORMATION: Please complete the following or send patient demographic sheet

Patient Name: ____________ Date of Birth: ____/____/____ Gender: ☐F ☐M

Address: ____________ City, State, Zip: ____________

Home Phone: ________ Alternate: ________ Email: ________

PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION

Diagnosis: ☐ B18.2 (Chronic Hepatitis C Virus) Diagnosis date: ________
Genotype: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 Subtype: ☐A ☐B ☐A/B ☐N/A
Baseline viralload: ________ Date: ________
Degree of fibrosis: ☐F0 ☐F1 ☐F2 ☐F3 ☐F4 ☐________
Cirrhosis: ☐None ☐Compensated ☐Decompensated (CTP: ☐B ☐C)
Co-infection(s): ☐ None ☐HIV ☐HBV

Transplant status: ☐N/A ☐Pre-transplant ☐Post-transplant
sCr: ________ GFR: ________ Date: ________
CKD stage: ☐1 ☐2 ☐3 ☐4 ☐5 ☐N/A Dialysis: ☐Yes ☐No
IL28B polymorphism: ☐CC ☐CT ☐TT
Q80K polymorphism: ☐Yes ☐No NS5A polymorphism: ☐Yes ☐No
NS5A polymorphism type: ☐M28 ☐Q30 ☐L31 ☐Y93 ☐________

Prior Regimen ☐ Naïve ☐ Experienced (List below)	Start Date	End Date	Treatment Weeks	Response *
________	________	________	________	☐IC ☐ NR ☐ PR ☐RLP
________	________	________	________	☐IC ☐ NR ☐ PR ☐ RLP
________	________	________	________	☐IC ☐ NR ☐ PR ☐ RLP

Response definitions: IC – Incomplete treatment, NR – Null Responder, PR – Partial Response, RLP - Relapser

Comorbidities: ____________

Concomitant Medications: ____________

Allergies: ☐ NKDA ☐ Other: ____________

PRESCRIPTION		QUANTITY	DURATION	REFILL
☐ **Daklinza®** (daclatasvir)	☐Take 30 mg by mouth once daily ☐Take 60 mg by mouth once daily ☐Take 90 mg by mouth once daily	☐ 28 x 30 mg tablets ☐ 28 x 60 mg tablets ☐ 28 x 90 mg tablets	☐ 12 weeks ☐ 24 weeks	____
☐ **Epclusa®** (velpatasvir/sofosbuvir)	☐Take 100 mg/400 mg by mouth once daily	☐ 28 x 100 mg/400 mg tablets	☐ 12 weeks ☐ 24 weeks	____
☐ **Harvoni®** (ledipasvir/sofosbuvir)	☐Take 90 mg/400 mg by mouth once daily	☐ 28 x 90 mg/400 mg tablets	☐ 8 weeks ☐ 12 weeks ☐ 24 weeks	____
☐ **Mavyret™** (glecaprevir + **pibrentasvir**)	☐Take 3 tablets by mouth once daily with food	☐ 84 x 100 mg/40mg tablets	☐ 8 weeks ☐ 12 weeks ☐ 16 weeks	____
☐ **Olysio®** (simeprevir)	☐Take 150 mg by mouth once daily	☐ 28 x 150 mg capsules	☐ 12 weeks ☐ 24 weeks	____
☐ **Sovaldi®** (sofosbuvir)	☐Take 400 mg by mouth once daily	☐ 28 x 400 mg tablets	☐ 12 weeks ☐ 24 weeks	____
☐ **Technivie™** (ombitasvir/paritaprevir/ritonavir)	☐Take 2 tablets by mouth in the morning wih food	☐ 56 x 12.5 mg/75 mg/50 mg tablets	☐ 12 weeks ☐ 24 weeks	____
☐ **Viekira Pak®** (dasabuvir/ombitasvir/paritaprevir/ritonavir)	☐Take 3 tablets by mouth in the morning and 1 tablet by mouth in the evening wih food	☐ 112 x 250 mg/12.5 mg/75 mg/50 mg tablets	☐ 12 weeks ☐ 24 weeks	____
☐ **Viekira XR™** (dasabuvir/ombitasvir/paritaprevir/ritonavir)	☐Take 3 tablets by mouth once daily wih food	☐ 84 x 200 mg/8.33 mg/50 mg/33.33 mg tablets		
☐ **Vosevi™** (sofosbuvir/velpatasvir/voxilaprevir)	☐Take 1 tablet by mouth once daily wih food	☐ 28 x 400 mg/100 mg tablets	☐ 12 weeks	____
☐ **Zepatier™** (elbasvir/grazoprevir)	☐Take 50 mg/100 mg by mouth once daily	☐ 28 x 50/100 mg tablets	☐ 12 weeks ☐ 16 weeks	____
☐ **Ribasphere® Ribapak® Dose Pak** (ribavirin) ☐ **Moderiba™ Dose Pack** (ribavirin)	☐Take ______ mg tablet by mouth every morning, ______ mg tablet by mouth every evening (______ mg/day)	☐ 28 x 200 mg; 28 x 400 mg ☐ 28 x 400 mg; 28 x 400 mg ☐ 28 x 400 mg; 28 x 600 mg ☐ 28 x 600 mg; 28 x 600 mg	Tablets	____
☐ **Ribasphere®**** (ribavirin)	☐Take ______ mg tablet by mouth every morning, ______ mg tablet by mouth every evening (______ mg/day)	☐ ____ x 200 mg	☐ Tablets ☐ Capsules	____

Physician Signature: ____________ Date: ____________

IMPORTANT NOTICE: This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the center at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitter material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.

For additional information please visit our website **www.RichmondSpecialty.com**

ePrescribe to our pharmacy "Richmond Pharmacy Specialty" • **(718) 818-2178**