

HEPATITIS C REFERRAL FORM

TODAY'S DATE _____

CURRENT PATIENT NEW PATIENT

PLEASE FAX REFERRAL FORM TO:

- BiologicTx - NJ**
TEL: 877-567-8087 FAX: 877-567-8089
- BiologicTx - CA**
TEL: 800-404-1963 FAX: 800-404-4595
- BiologicTx - IL**
TEL: 888-892-7607 FAX: 877-567-8089
- Decillion Healthcare**
TEL: 800-622-9321 FAX: 866-548-8849

- Elwyn Specialty Care**
TEL: 855-359-9679 FAX: 610-545-6030
- Factor Support Network**
TEL: 877-376-4968 FAX: 805-482-6324
- Matrix Health**
TEL: 877-337-3002 FAX: 888-385-2805
- Med Center Specialty Pharmacy**
TEL: 855-633-5633 FAX: 304-344-0655
- MedEx BioCare**
TEL: 800-962-6339 FAX: 901-382-3091

Patient Name _____ SS# _____ DOB _____ Male Female
 Street Address _____ Apt# _____ City _____ State _____ Zip _____
 Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____ BSA _____
 Ship to Patient at Home Work OR Patient will pick up at Physician Office Local Pharmacy Phone _____
 Allergies _____ Comorbidities _____
 Current Medications (if necessary, please fax a complete list) _____

PRACTICE NAME	ADDRESS	PHONE	PRIMARY CONTACT

PRESCRIBER INFORMATION (PLEASE INCLUDE PHYSICIAN NAME AND NPI#)

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

Insured's Name _____ Relation to Patient _____
 Eligible for Medicare Yes No If yes, Medicare# _____ Prescription Card Yes No If Yes, Carrier _____
 Tel _____ Fax _____ Policy/Group# _____
 Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

ICD-10 Code B18.2 HCV (Chronic) B19.2 F Score _____ relapsed partial response null response
 Previously treated No Yes, what drugs _____ Interferon Yes No # of Weeks _____
 Cirrhosis Yes No Compensated Decompensated
 HCV MEDICAL CRITERIA Genotype _____ HCV-Viral Load _____ (IU) Date of Labs _____ ALT _____ AST _____ Hgb _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

MAVYRET Glecaprevir 100 mg / Pibrentasvir 40 mg tablet
 SIG: Take 3 tablets by mouth daily with food QTY: 84 Refills: _____
 Other: _____ QTY: _____ Refills: _____

VOSEVI Sofosbuvir 400 mg / Velpatasvir 100 mg / Voxilaprevir 100 mg tablet
 SIG: Take 1 tablet by mouth daily for 12 weeks QTY: _____ Refills: _____
 Other: _____ QTY: _____ Refills: _____

EPCLUSA Sofosbuvir 400 mg / Velpatasvir 100 mg tablet
 SIG: Take 1 tablet by mouth daily for 12 weeks
 Take 1 tablet by mouth daily for 12 weeks WITH Ribavirin
 QTY: 28 Refills: _____

HARVONI Ledipasvir 90 mg / Sofosbuvir 400 mg tablet
 SIG: Take 1 tablet by mouth daily QTY: 28 Refills: _____

DAKLINZA 30 mg / 400 mg SOVALDI QTY: 28 Refills: _____
 60 mg / 400 mg SOVALDI QTY: 28 Refills: _____
 90 mg / 400 mg SOVALDI QTY: 28 Refills: _____
 SIG: take 1 tablet each daily Total daily dose: _____ GT3 ONLY

RIBAVIRIN **MODERIBA** **RIBAPAK**
 600mg PO Daily; 200mg QAM, 400mg QPM
 800mg PO Daily; 400mg QAM, 400mg QPM
 1000mg PO Daily; 600mg QAM, 400mg QPM
 1200mg PO Daily; 600mg QAM, 600mg QPM
 Other 200mg Sig _____
 QTY: 28 Day Supply Refills: _____

OLYSIO 150 mg capsule
 SIG: Take 1 capsule by mouth daily for 12 weeks
 with peginterferon and ribavirin
 QTY: 28 Refills: _____

SOVALDI Sofosbuvir 400 mg tablet
 SIG: Take one tablet by mouth daily QTY: 28 Refills: _____

ZEPATIER Grazoprevir 100 mg/ Elbasvir 50 mg tablet
 SIG: Take one tablet by mouth daily QTY: 28 Refills: _____

PEG INTRON REDIPEN VIAL
 Strength (Dose) 50 mcg/0.5ml 120 mcg/0.5ml
 80 mcg/0.5ml 150 mcg/0.5ml
 Directions: _____
 QTY: 1 month 3 months Refills: _____

PEGASYS
 ProClick 180 mcg Autoinjector (NDC 004-0365-30)
 Inject subcutaneously weekly
 Pre-Filled Syringe 180 mcg/0.5ml (NDC 004-0357-30)
 Inject subcutaneously weekly
 Other _____
 QTY: 1 month 3 months Refills: _____

VIEKIRA PAK
 Ombitasvir/Paritaprevir/Ritonavir 12.5mg/75 mg/50 mg tabs (pink) Dasabuvir 250 mg tab (beige)
 Directions: Take two pink tabs PO once daily (AM) with food and one beige tab PO twice daily (AM and PM) with food
 QTY: 112 Refills: _____

NEUPOGEN 300 mcg 480 mcg
 Sig: _____ QTY: _____ Refills: _____

PROCRIT
 Sig: _____ QTY: _____ Refills: _____

OTHER _____
 Sig: _____
 QTY: _____ Refills: _____

By signing this form and utilizing our services, you are authorizing BioMatrix Specialty Pharmacy, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) _____ Dispense as written **Date** _____

Prescriber's Signature (signature required. NO STAMPS) _____ Product Substitution Permitted **Date** _____

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