HEPATITIS C REFERRAL FORM

GLEN ROCK Medical Pharmacy
Part of The Elwyn Pharmacy Group
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August 2017

Today's Date

☐ CURRENT PATIENT
☐ NEW PATIENT

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	PRACTICE ADDRESS	CONTACT INFORMATION	LICENSE INFORMATION

REFERRAL SOURCE INFORMATION

☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____

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# _____

Previously treated ☐ No ☐ Yes, what drugs _____ Interferon ☐ Yes ☐ No # of Weeks _____
ICD-10 Code ☐ B18.2 HCV (Chronic) ☐ B19.2 F Score_____ ☐ relapsed ☐ partial response ☐ null response
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** 100 mg glecaprevir / 40 mg pibrentasvir tablet
SIG: ☐ Take 3 tablets by mouth daily with food Qty: 84 Refills: _____
☐ Other:_____ Qty:_____ Refills: _____

☐ **VOSEVI** 400 mg sofosbuvir / 100 mg velpatasvir / 100 mg voxilaprevir 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 90mg / Sofosbuvir 400mg 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 dailly 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: _____

☐ **TECHNIVIE** paritaprevir / ritonavir (75/50 mg) and ombitasvir (12.5 mg)
SIG: two tablets QAM with meal and with ☐ RIBAVIRIN
Qty: 28 Day Supply Refills: _____ GT4 ONLY

☐ **OLYSIO** 150mg capsule Qty: 28 Refills: _____
SIG: Take 1 capsule by mouth daily for 12 wks w/ peginterferon and ribavirin

☐ **SOVALDI** (Sofosbuvir) 400mg tablet
SIG: Take 1 tablet by mouth daily Qty: 28 Refills: _____

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

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

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

☐ **VIEKIRA XR** Dasabuvir 200mg/ Ombitasvir 8.33mg/ Paritaprevir 50mg/ Ritonavir 33.33mg
SIG: Take 3 tablets PO QAM with meal for:
☐ 12 weeks w/ Ribavirin (GT 1a, w/o cirrhosis)
☐ 24 weeks w/ Ribavirin (GT 1a, w/ compensated cirrhosis)
☐ 12 weeks (GT 1b, w/ or w/o compensated cirrhosis)
Qty: 84 Refills: _____

☐ **VIEKIRA PAK** QTY: 112 Refills: _____
Ombitasvir/Paritaprevir/Ritonavir 12.5mg/75 mg/50 mg tabs (pink) Dasabuvir 250 mg tab (beige)
Directions: Take 2 pink tabs PO once daily (AM) with food and one beige tab PO twice daily (AM and PM) with food

NEUPOGEN ☐ 300 mcg ☐ 480mcg
Sig _____ Qty:_____ Refills: _____

PROCRIT
Sig _____ Qty:_____ Refills: _____

OTHER _____
Sig _____ Qty _____ Refills _____

By signing this form and utilizing our services, you are authorizing Glen Rock Medical Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

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

Please fax completed referral form to **Glen Rock Medical Pharmacy** at **201-444-5792** Visit **www.GLENROCKMEDICALPHARMACY.com** for online fillable forms.

NEW REFERRAL CHECKLIST

PLEASE USE THIS CHECKLIST FOR HEPATITIS C PATIENTS

Please use the attached checklist as a reference in order to provide the proper documentation to process the required prior authorization for your patient's treatment. All lab reports (or EMR) must contain the following information within the last 30 days.

Please forward any updates to us you receive from the insurance company regarding approvals or denials

REQUIRED INFORMATION:

- ☐ Patient name
- ☐ Patient Demographics (Address, Phone Number, DOB, etc…)
- ☐ Medication list and allergies
- ☐ Insurance information with RX insurance. Please include copy of card.
  If the only card included is a medical card, please include local pharmacy information.
- ☐ MD name/NPI/Office contact/Phone number
- ☐ Drug indicated with refills and planned treatment duration
- ☐ MD signature and date on referral form

CLINICAL INFORMATION: PREFERABLY, LABS AND TEST RESULTS SHOULD BE WITHIN 8-12 WEEKS OF THE DATE ON THE REFERRAL:

- ☐ Patient weight
- ☐ Genotype (hard copy from lab)
- ☐ HCV RNA (Viral load)
- ☐ Lab results with CBC, ALT/AST, HGB, INR, HFP AND GFR
- ☐ NS5A Lab (required for Zepatier 1a patients)
- ☐ Liver biopsy/Metavir/FibroSure lab
  (Most plans are still requiring stage 3 – 4 fibrosis, but others simply need to see some form of test)
- ☐ Has patient had a liver transplant
- ☐ Is the patient co-infected HIV/Hep C?
- ☐ Previous treatment with medications, dates, and outcome
- ☐ Drug/alcohol test (if applicable)

Fax the requested documentation to 201-444-5792

Toll Free: 1-866-888-3200 Direct Phone: 201-444-3200

www.GlenRockMedicalPharmacy.com

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