

HEPATITIS C REFERRAL FORM

210 Rock Road | Glen Rock, NJ 07452
TEL: 201-444-3200 | FAX: 201-444-5792
Toll Free: 866-888-3200

Today's Date

CURRENT PATIENT
 NEW PATIENT

FEB 2018

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			
<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"/>	# _____	<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# _____

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: _____

EPLUSA 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 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: _____

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 _____ 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** _____

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 are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

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

