RE PHARMACY
PASSION FOR LIFE

866 413-3156 toll free phone
877 834-1231 toll free fax
QUESTIONS? Please Contact Us!
www.REPharmacy.com

Hepatitis C/Hepatology Referral Form

Send your Rx to: (optional)
Select Location

Date Medication Needed: _____ Ship To: (☐) Patient's Home (☐) Prescriber's Office (☐) Pick-Up (store location): _____

1) Patient & Insurance Information

Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

Patient Name: _____ Birth Date: _____ Sex: (○) Male (○) Female Height: _____ Weight: _____ ( ) lbs. ( ) kgs.
Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
Address: _____ City: _____ State: _____ Zip: _____
Insurance Info: _____ Policy Number: _____

2) Prescriber Information

Provider Name: _____ DEA #: _____ NPI #: _____ Tax ID#: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Key Contact: _____ Phone: _____

3) Diagnosis/Clinical Information

Please FAX recent clinical notes, labs and/or tests, with the prescription, to expedite the prior authorization.

Diagnosis:
- ☐ B18.2 Hepatitis C
- ☐ K72.9 Hepatic Encephalopathy
- ☐ _____

Genotype:
- ☐ 1a ☐ 3 ☐ 5
- ☐ 1b ☐ 4 ☐ 6
- ☐ 2

For XIFAXAN:
Prior drug tried & failed:
- ☐ Cipro ☐ Neomycin ☐ Flagyl
- ☐ Lactulose ☐ Tetracycline
- ☐ _____

Does patient have Cirrhosis?(☐) Yes (☐) No
Fibrosis Score: _____
Date: _____

For Hepatitis:
Most recent lab date:
AST: _____
ALT: _____
HCV RNA: _____ (viral load)

- ☐ Naive patient
- ☐ Non-responder*
- ☐ Relapser*

*Initial therapy
Start Date: _____
Length: _____

Does patient need nurse training? (☐) Yes (☐) No

4) Prescription Information

- ☐ **VOSEVI®** (sofosbuvir 400mg, velpatasvir 100mg, and voxilaprevir 100mg) Disp#28 Sig: one daily Refill: _____ Duration of therapy: _____ weeks
- ☐ **ZEPATIER®** (50mg elbasvir/100mg grazoprevir) Disp#28 Sig: one daily Refill: _____ Duration of therapy: _____ weeks
- ☐ **HARVONI®** (90mg ledipasvir/400mg sofosbuvir) Disp#28 Sig: one daily Refill: _____ Duration of therapy: _____ weeks
- ☐ **EPCLUSA®** (sofosbuvir 400mg and velpatasvir 100mg) Refill: _____ Duration of therapy: _____ weeks
  - ☐ Sig: One daily [patients without cirrhosis or with compensated cirrhosis (Child-Pugh class A)].
  - ☐ Sig: One daily in combination with ribavirin [patients with decompensated cirrhosis (Child-Pugh class B or C)].
- ☐ **VIEKIRA PAK®** Disp#28 Refill: _____ Duration of therapy: _____ weeks
  - ☐ Sig: Take 2 ombitasvir, paritaprevir, ritonavir 12.5/75mg/50mg QAM, and 1 dasabuvir 250mg bid with meal.
- ☐ **VIEKIRA XR®** ☐ 200mg ☐ 8.33mg ☐ 50mg ☐ 33.33mg (Tablet extended-release 24 Hour). Disp#84
  - ☐ Sig: Extended-release: 3 tablets once a day.
- ☐ **RIBAVIRIN** Disp#28 Refill: _____ Duration of therapy: _____ weeks
  - ☐ Sig: 1200mg daily/600mg QAM — 600mg QPM
  - ☐ Sig: 1000mg daily/600mg QAM — 400mg QPM

  < 75kg = 1000mg/day ≥ 75kg = 1200mg/day
- ☐ **SOVALDI®** (sofosbuvir) 400mg Disp#28 Sig: one daily Refill: _____ Duration of therapy: _____ weeks
- ☐ **OLYSIO®** (simeprevir) 150mg Disp#28 Sig: one daily Refill: _____ Duration of therapy: _____ weeks
- ☐ **DAKLINZA** (daclatasvir) ☐ 30mg ☐ 60mg Disp#28 Sig: one daily Refill: _____ Duration of therapy: _____ weeks
- ☐ **TECHNIVIE®** (12.5mg ombitasvir/75mg paritaprevir/50mg ritonavir) Disp#28 Sig: two daily Refill: _____ Duration of therapy: _____ weeks
- ☐ **PEGASYS®:**
- ☐ **MAVYRET®**
  - ☐ Sig: 3 tablets once daily for 8 weeks (without cirrhosis) or 12 weeks (with compensated cirrhosis) [Child-Pugh A]).
  - ☐ Genotype 1: Prior treatment with an NS5A inhibitor containing regimen without an NS3/4A PI: 3 tablets once daily for 16 weeks.
  - ☐ Genotype 1: Prior treatment with an NS3/4A PI: 3 tablets once daily for 12 weeks.
- ☐ **PROMACTA®** _____ mg Disp#30 Sig: one daily Refill: _____ Duration of therapy: _____ weeks
- ☐ **Other:**

5) Prescriber Signature

Prescriber, please sign and date below.

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Dispense as written _____ Date _____ Substitution Permissable _____ Date _____

#of Prescriptions

Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.