HEPATITIS C REFERRAL FORM

V-Care Pharmacy
Specialty + Medical & Surgical Supplies
151 Cochituate Rd | Framingham, MA 01701
Ph 508.202.9993 | 844.7.MYVCARE | Fx 508.202.9343 | Fx 844.230.6211

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

OCT 2017

Patient Name First Name Last Name SS# DOB Height Weight ☐ Male ☐ Female
Street Address Apt # City State Zip
Daytime Tel Evening Tel Cell Email
Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ V-Care Pharmacy Date Needed
Allergies Comorbidities
Current Medications (if necessary, please fax a complete list)

Previously treated ☐ No ☐ Yes, what drugs Interferon ☐ Yes ☐ No # of Weeks ☐ relapsed ☐ partial response ☐ null response
ICD-10 Code ☐ B18.2 HCV (Chronic) Liver Biospsy ☐ Yes ☐ No Date Results
HCV MEDICAL CRITERIA Genotype HCV-Viral Load (IU) Date of Labs ALT AST Hgb

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#

Prescriber's Name Office Contact
Street Address Suite # City State Zip
Tel Fax Email
License# NPI# UPIN# DEA#

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

MAVYRET ☐ 100 mg glecaprevir/40 mg pibrentasvir tablet
SIG: ☐ Take 3 tablets PO once daily with food QTY:____ Refill:____
☐ Other:_____ QTY:____ Refill:____

VOSEVI ☐ 400 mg sofosbuvir/100 mg velpatasvir/100 mg voxilaprevir tablet
SIG: ☐ Take 1 tablet PO daily w/ food for 12 wks QTY:____ Refill:____
☐ Other:_____ QTY:____ Refill:____

EPCLUSA ☐ Sofosbuvir 400 mg/Velpatasvir 100 mg tablet
SIG: ☐ Take1 tablet once a day for 12 weeks QTY:____ Refill:____
☐ 1 tab 1x day for 12 weeks WITH ribavirin QTY:____ Refill:____

HARVONI ☐ Ledipasvir 90mg / Sofosbuvir 400mg
SIG: Take 1 tablet by mouth daily QTY: 28 Refill:____

ZEPATIER ☐ Grazoprevir 100mg/ Elbasvir 50mg tablet GT 1 & 4 ONLY
NS5A test for GT1a patients ☐ Yes ☐ No
SIG: Take one tablet by mouth daily QTY: 28 Refill:____

SOVALDI (Sofosbuvir) 400mg tablet
Take 1 tablet by mouth daily for:
☐ 12 weeks w/ Ribavirin and peginterferon (Genotype 1 or 4)
☐ 12 weeks with Ribavirin (Genotype 2)
☐ 24 weeks (Genotype 3)
QTY _____ Refill:____

DAKLINZA Genotype 3 ONLY
☐ 30 mg / ☐ 400 mg SOVALDI QTY: 28 Refill:____
☐ 60 mg / ☐ 400 mg SOVALDI QTY: 28 Refill:____
SIG: take 1 tablet each daily Total daily dose:_____

RIBAVIRIN® | RIBAPAK
☐ Ribapak 600mg PO Daily; 200mg QAM, 400mg QPM
☐ Ribapak 800mg PO Daily; 400mg QAM, 400mg QPM
☐ Ribapak 1000mg PO Daily; 600mg QAM, 400mg QPM
☐ Ribapak 1200mg PO Daily; 600mg QAM, 600mg QPM
☐ Ribavirin 200mg Sig _____
QTY:_____ Refill:_____

TECHNIVIE
☐ Paritaprevir/Ritonavir (75/50 mg) & Ombitasvir (12.5 mg)
SIG: two tabs QAM w/ meal and w/ ☐ RIBAVIRIN
QTY:_____ Refill:_____ GT 4 ONLY

☐ VIEKIRA XR
Dasabuvir 200mg/ Ombitasvir 8.33mg/ Paritaprevir 50mg/ Ritonavir 33.33mg
SIG: Take 3 tablets PO with meal for:
☐ 12 wks w/ Ribavirin (GT 1a, w/o cirrhosis)
☐ 24 wks w/ Ribavirin (GT1a, w/ compensated cirrhosis)
☐ 12 weeks (GT 1b, w/ or w/o compensated cirrhosis)
QTY:_____ Refill:_____

VIEKIRA ☐ Ombitasvir/Paritaprevir/ Ritonavir 12.5mg/75 mg/50 mg tablets (pink) and Dasabuvir 250 mg tablet (beige)
Directions: Take 2 pink tablets PO once daily (AM) with food and one beige tablet PO twice daily (AM and PM) with food.

By signing this form and utilizing our services, you are authorizing V-Care 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 **V-Care Pharmacy & Surgical Supplies** at **508.202.9343** or **844.230.6211** Visit us at **WWW.MYVCAREPHARMACY.COM** for online fillable forms.