InfuCare Rx

Hepatitis C Referral Form

of Pages Faxed:__________
Fax Referral To: 877-828-3941
Phone: 877-828-3940

Date Required:__________ Ship To: ☐ Home ☐ Office ☐ Other:__________

PATIENT INFORMATION

Patient Name: __________
Address: __________
City, State, Zip: __________
Home Phone: __________
Cell Phone: __________
Alternate Phone: __________
Date of Birth: __________ Gender: ☐ Male ☐ Female

PRESCRIBER INFORMATION

Prescriber Name: __________
Address: __________
City, State, Zip: __________
Phone: __________
Fax: __________
DEA #: __________ NPI #: __________
Contact Person: __________

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: __________ ID: __________ Group: __________
Secondary Insurance: __________ ID: __________ Group: __________
Prescription Card: __________ ID: __________ BIN: __________ PCN: __________

DIAGNOSIS & LAB WORK (Please attach clinical notes for prior authorization process)

Primary Diagnosis: ☐ 070.54 Hepatitis C Chonic Genotype: ☐ 1a ☐ 1b ☐ 2 ☐ 3 ☐ 4 HIV Co-Infected: ☐ Yes ☐ No
Compensated Cirrhosis? ☐ Yes ☐ No Weight: __________ Patient Allergies: ☐ NDKA ☐ Yes __________
Previously Treated with Interferon? ☐ No, patient is Naïve ☐ Yes **If yes, patient is a:** ☐ Partial Responder ☐ Relapser ☐ Null Response
Labwork: Baseline HCV-RNA: __________ Date: __________ Result: __________ IU/ml
☐ CBC ☐ Hepatic Function Panel or CMP ☐ HCV RNA QN ☐ Q80K ☐ Liver Biopsy and / or Fibrosure / Fibroscan
Liver Transplant: ☐ Yes ☐ No Waiting for a Liver Transplant: ☐ Yes ☐ No Hepatocellular Carcinoma: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

☐ Patient to be trained for medication administration in physician clinic.

☐ Procrit ☐ 2,000 ☐ 3,000 ☐ 4,000 ☐ 10,000
☐ Epogen Dose: __________ SIG: __________ QTY: __________ Refill: __________

☐ Neupogen ☐ 300mcg ☐ 480mcg
Dose: __________ SIG: __________ QTY: __________ Refill: __________

☐ Ribavirin 200mg
Directions: __________
Quantity: __________
Refill: x __________
Total duration of therapy: __________ Weeks
☐ < 75kg = 1000mg/day
☐ ≥ 75kg = 1000mg/day

RibaPak (28 day supply):
☐ 1200mg daily / 600mg QAM— 600mg QPM
☐ 1000mg daily / 600mg QAM— 400mg QPM
☐ 800mg daily / 400mg QAM— 400mg QPM
☐ 600mg daily / 200mg QAM— 400mg QPM
Total duration of therapy: __________ Weeks

Moderiba (28 day supply):
☐ 1200mg daily / 600mg QAM— 600mg QPM
☐ 1000mg daily / 600mg QAM— 400mg QPM
☐ 800mg daily / 400mg QAM— 400mg QPM
☐ 600mg daily / 200mg QAM— 400mg QPM
Total duration of therapy: __________ Weeks

Inhibitor of HCV NS5A / Nucleotide Analog Inhibitor:
☐ HARVONI ® (ledipasvir 90mg / sofosbuvir 400mg) disp. 28 Sig: 1 tablet daily Refill: x ______ Total duration of therapy: __________ Weeks

Protease Inhibitor:
☐ OLYSIO™ (simeprevir) 150mg caps disp. 28 Sig: 150mg daily with food Refill: x ______ Total duration of therapy: __________ Weeks

Nucleotide Polymerase Inhibitor:
☐ Sovaldi™ (sofosbuvir) 400mg disp. 28 Sig: 400mg daily Refill: x ______ Total duration of therapy: __________ Weeks

NS5A Inhibitor / NS3 / 4A Protease Inhibitor / Non-Nucleoside NS5B Palm Polymerase Inhibitor:
☐ VIEKIRA PAK disp. 28 day supply. Refill: x ______ Total duration of therapy: __________ Weeks
Sig: Take two ombitasvir, paritaprevir, ritonavir 12.5mg / 75mg / 50mg tablets once daily (in am) and 1 dasabuvir 250mg tablet twice daily (am & pm) with a meal.

☐ Pegasys: ☐ 180mcg Proclick Autoinjector ☐ 135mcg Proclick Autoinjector ☐ 180mcg / 0.5ml prefilled syringe
Dose: _____ SC once weekly as directed ______ 1-month supply ________ ☐ Refill: x ______ Total duration of therapy: __________ Weeks

Supportive Therapy: ☐ Promacta* PO QD ☐ 12.5mg tablets ☐ 25mg tablets ☐ 50mg tablets ☐ 75mg tablets ☐ 100mg tablets
Quantity: _______ Refill: x _______ Total duration of therapy: __________ Weeks *Titrate based on platelet count not to exceed 100mg PO QD

Prescriber Signature: __________ **Date:** __________

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