InfuCare Rx

Hepatology Referral Form

of Pages Faxed:_____
Fax Referral To: 844-504-3278
Phone: 877-327-8881

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: ☐ B18.2 Chronic Hep C ☐ C22.0 Hepatocellular Carcinoma ☐ Other:_____

Genotype: ☐ 1 ☐ 1a ☐ 1b ☐ 2 ☐ 2a ☐ 2b ☐ 3 ☐ 3a ☐ 3b ☐ 4 ☐ 4a ☐ 4b ☐ Other:_____ Viral Load:_____

Compensated Cirrhosis? ☐ Yes ☐ No Weight:_____ Patient Allergies: ☐ NDKA ☐ Yes_____ HIV Co-Infected: ☐ Yes ☐ No

Previous Treatment?_____ ☐ 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

Drug:	Strength:	Directions:	Quantity:	Refills:
☐ Baraclude®	☐ 1mg ☐ 5mg	☐ Take 1 tablet daily	☐ 30 days	
☐ Daklinza®	☐ 60mg ☐ 30mg	☐ Take 1 tablet daily	☐ 28 days	
☐ Epclusa®	☐ 400mg/100mg	☐ Take 1 tablet daily with or without food	☐ 28 days	
☐ Epivir-HBV®	☐ 100mg	☐ Take 1 tablet daily	☐ 30 days	
☐ Harvoni®	☐ 90-400 mg tablets	☐ Take 1 tablet daily with or without food	☐ 28 days	
☐ Hepsera®	☐ 10mg	☐ Take 1 tablet daily	☐ 30 days	
☐ Olysio®	☐ 150mg cap	☐ Take 1 capsule by mouth once daily with food	☐ 28 days	
☐ Ribapak® ☐ Moderiba Pak®	☐ Less than 66 kgs (145lbs) ☐ 66-80 kgs (145-176lbs) ☐ 81-105 kgs (178-231lbs) ☐ Greater than 105 kgs (231lbs)	☐ Take 400mg QAM and 400mg QPM ☐ Take 600mg QAM and 400mg QPM ☐ Take 600mg QAM and 600mg QPM ☐ Take 600mg Qam and 600mg QPM with 200mg Ribasphere	☐ 28 days	
☐ Ribasphere®	☐ 200mg tab ☐ 200mg cap	☐ _____	☐ 28 days	
☐ Solvaldi®	☐ 400mg	☐ Take 1 tablet by mouth daily	☐ 28 days	
☐ Technivie®	☐ 12.5/75/50mg	☐ Take 2 tablets by mouth daily with food	☐ 28 days	
☐ Victrelis®	☐ 200mg	☐ Take 4 tablets three times daily with food	☐ 28 days	
☐ Viekera®	☐ 28 Day Pack	☐ Take 2 (ombitasvir, paritaprevir, ritonavir 12.5/75/50mg) tablets every morning and take 1 (dasabuvir 250mg) tablet every morning and evening with a meal	☐ 28 days	
☐ Zepatier®	☐ 50mg/100mg	☐ Take 1 tablet daily with or without food	☐ 28 days	
☐ Other:_____	☐ _____	☐ _____	☐ _____	

ADDITIONAL COMMENTS

Prescriber Signature:_____ **Date:**_____