benevere PHARMACY

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beneverepharmacy.com

TODAY'S DATE: ______________
☐ NEW PATIENT ☐ CURRENT PATIENT

HEPATITIS C REFERRAL FORM

PATIENT INFORMATION

Patient Name ______________________
Address ______________________
City ______________ State __________ ZIP __________
Home Phone ______________ Cell __________
DOB ______________ SSN __________
Drug Allergies ______________ ☐ Male ☐ Female

PRESCRIBER INFORMATION

Prescriber Name ______________ DEA __________
NPI# ______________ Tax ID __________
Practice Name ______________________
Address ______________ Suite __________
City ______________ State __________ ZIP __________
Office Phone ______________ Fax __________

INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Insurance ______________________
Policy ______________ Group __________
Insurance Phone ______________________
Prescription Drug Coverage Company ______________________
RXGRP# ______________ RXBIN# __________

Secondary Insurance (if applicable) ______________________
Policy ______________ Group __________
Insurance Phone ______________________
Phone ______________________
PCN/ID# ______________________

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARDS

CLINICAL INFORMATION

Diagnosis: ☐ B18.2 Chronic Hepatitis C without hepatic coma ☐ Other ______________ Genotype __________ Diagnosis date: __________

HCV viral load ______________ IU/ml METAVIR: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4 ☐ Other Polymorphism: ______________

Previous Treatment: ☐ Naïve ☐ Relapse ☐ Treatment Failure Previous Regimen/Duration: ______________ CKD Stage: __________

Dialysis: ☐ Yes ☐ No Child-Pugh: ☐ A ☐ B ☐ C Co-infection? ☐ HBV ☐ HIV If applicable, please send all clinical information pertinent to the patient's co-infection. Scr ________ Date ________

PLEASE ATTACH A LIST OF PATIENT'S CURRENT MEDICATIONS.

DRUG NAME	DOSE	DIRECTIONS FOR USE	QTY.	REFILLS
☐ Daklinza®	60mg tablet	☐ Take once daily with or without food. ☐ Clinical Pharmacist consult on dosing for cytochrome P450 drug/drug interactions ☐ ______________	28 day supply	
☐ Epclusa®	400/100mg	Take once daily with or without food.	28 day supply	
☐ Harvoni®	90/400mg	Take once daily with or without food.	28 day supply	
☐ Mavyret®	300/120mg	Take 3 tablets once daily with food.	☐ 28 day supply ☐ 56 day supply	
☐ Moderiba® ☐ RibaPak®	***Weight (kg)*** ***Strength (Dose)*** ≤ 75 1000 mg/day > 75 1200 mg/day Dose reduction required with renal insufficiency.	☐ 600mg P O Daily; 200mg QAM, 400mg QPM ☐ 800mg P O Daily; 400mg QAM, 400mg QPM ☐ 1000mg P O Daily; 600mg QAM, 400mg QPM ☐ 1200mg P O Daily; 600mg QAM, 600mg QPM Divided and administered twice-daily with food.	28 day supply	
☐ Ribavirin	☐ 200mg tablets ☐ 200mg capsules	Sig: ______________	28 day supply	
☐ Sovaldi®	400mg tablet	Take once daily with or without food.	28 day supply	
☐ Technivie® Pak		Take 2 tablets in the morning with a meal per pack directions	28 day supply	
☐ Viekira® Pak		Take 3 tablets in the morning and 1 tablet at night with a meal per pack directions.	28 day supply	
☐ Viekira® XR		Take 3 tablets by mouth once daily with food	28 day supply	
☐ Vosevi®	400/100/100mg	Take once daily with food.	28 day supply	
☐ Zepatier®	50/100mg	Take once daily with or without food. *For HCV 1a patients, please send baseline NS5A resistance-associated polymorphism test results.*	28 day supply	

Deliver to: ☐ Patient's home ☐ MD's Office ☐ 1st dose to MD's Office, remaining refills to patient's home

Prescriber's Signature (signature required. NO STAMPS) ______________________ Date ______________

By signing this form and utilizing our services, you are authorizing Benevere and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

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