

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 _____ Secondary Insurance (if applicable) _____
 Policy _____ Group _____ Policy _____ Group _____
 Insurance Phone _____ Insurance Phone _____
 Prescription Drug Coverage Company _____ Phone _____
 RXGRP# _____ RXBIN# _____ 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	WEEKS
<input type="checkbox"/> Daklinza®	60mg tablet	<input type="checkbox"/> Take once daily with or without food. <input type="checkbox"/> Clinical Pharmacist consult on dosing for cytochrome P450 drug/drug interactions <input type="checkbox"/> _____	<input type="checkbox"/> 12 <input type="checkbox"/> 24
<input type="checkbox"/> Epclusa®	400/100mg	Take once daily with or without food.	<input type="checkbox"/> 12 <input type="checkbox"/> 24
<input type="checkbox"/> Harvoni®	90/400mg	Take once daily with or without food.	<input type="checkbox"/> 8 <input type="checkbox"/> 12 <input type="checkbox"/> 24
<input type="checkbox"/> Mavyret®	300/120mg	Take 3 tablets once daily with food.	<input type="checkbox"/> 8 <input type="checkbox"/> 12 <input type="checkbox"/> 16
<input type="checkbox"/> Moderiba® <input type="checkbox"/> RibaPak®	Weight (kg) Strength (Dose) ≤ 75 1000 mg/day > 75 1200 mg/day Dose reduction required with renal insufficiency.	<input type="checkbox"/> 600mg P O Daily; 200mg QAM, 400mg QPM <input type="checkbox"/> 800mg P O Daily; 400mg QAM, 400mg QPM <input type="checkbox"/> 1000mg P O Daily; 600mg QAM, 400mg QPM <input type="checkbox"/> 1200mg P O Daily; 600mg QAM, 600mg QPM Divided and administered twice-daily with food.	<input type="checkbox"/> 8 <input type="checkbox"/> 12 <input type="checkbox"/> 16 <input type="checkbox"/> 24
<input type="checkbox"/> Ribavirin	<input type="checkbox"/> 200mg tablets <input type="checkbox"/> 200mg capsules	Sig: _____	<input type="checkbox"/> 8 <input type="checkbox"/> 12 <input type="checkbox"/> 16 <input type="checkbox"/> 24
<input type="checkbox"/> Sovaldi®	400mg tablet	Take once daily with or without food.	<input type="checkbox"/> 12 <input type="checkbox"/> 24 <input type="checkbox"/> 48
<input type="checkbox"/> Technivie® Pak		Take 2 tablets in the morning with a meal per pack directions	<input type="checkbox"/> 12
<input type="checkbox"/> Viekira® Pak		Take 3 tablets in the morning and 1 tablet at night with a meal per pack directions.	<input type="checkbox"/> 12 <input type="checkbox"/> 24
<input type="checkbox"/> Viekira® XR		Take 3 tablets by mouth once daily with food	<input type="checkbox"/> 12 <input type="checkbox"/> 24
<input type="checkbox"/> Vosevi®	400/100/100mg	Take once daily with food.	<input type="checkbox"/> 12
<input type="checkbox"/> Zepatier®	50/100mg	Take once daily with or without food. <i>For HCV 1a patients, please send baseline NS5A resistance-associated polymorphism test results.</i>	<input type="checkbox"/> 12 <input type="checkbox"/> 16

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 its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

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