Hepatitis C Referral Form

THE HONOLULU PHARMACY
COMPOUNDING PHARMACY & SPECIALTY PHARMACY

Phone: 808-533-8887
Fax: 808-533-1888
E-Prescribing Available

Attention: _____ Need By Date: _____ First Ship To: ☐ Patient ☐ Physician

Patient

Patient Name:_____ DOB: _____ Sex: ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
Home#: _____ Work #: _____ Cell#: _____ Best time to call: ☐ AM ☐ PM
Soc. Sec #: _____-_____-_____ Ethnicity: _____ Primary Language: _____
Comorbidities: _____ Height: _____ Weight:_____ Date:_____
Allergies: _____ ☐ NKDA

Provider

Physician Name:_____ Practice Name:_____ State Lic#: _____ DEA#: _____
Address:_____ City:_____ State:_____ Zip:_____ NPI#: _____
Phone#: _____ Fax#: _____ Nurse/Key Office Contact: _____ Ext.: _____

Insurance

Primary Insurance: _____ ID: _____ Phone: _____
Secondary Insurance: _____ ID: _____ Phone: _____
* Please provide a copy of the insurance card (front and back) and MEDICATION LIST

Clinical Info

Diagnosis/ICD-10: 318.2 HCV (chronic) other:_____
Patient type: ☐ naïve ☐ relapse ☐ partial responder ☐ null responder
Cirhosis: ☐ Yes ☐ No if yes, is it: ☐ compensated ☐ decompensated
Metavir score: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4
Activity: ☐ A0 ☐ A1 ☐ A2 ☐ A3
Child Pugh Score: ☐ A ☐ B ☐ C
Is the patient interferon-intolerant? ☐ Yes ☐ No

Genotype/Subtype: _____/_____
For genotype 1a, is the Q80K polymorphism present? ☐ Yes ☐ No
Baseline Viral Load: _____ IU/ml
Fibroscan™: _____ kPa FibroSURE®: _____
Is patient awaiting liver transplantation for hepatocellular carcinoma?
☐ Yes ☐ No

Prescription

Medication	Dose	Frequency	Quantity	Refill
☐ **Ribavirin** 200mg capsules or tablets	Take _____mg PO in AM & _____mg PO in PM		28 days supply	_____
☐ **Harvoni®** (ledipasvir/sofosbuvir)	☐ 90mg/400mg tablet	☐ Orally one time daily for 8 weeks ☐ Orally one time daily for 12 weeks ☐ Orally one time daily for 24 weeks	28 days supply	_____
☐ **Zepatier®** (elbasvir & grazoprevir)	☐ 50mg/100mg tablet	☐ Orally one time daily for 12 weeks ☐ Orally one time daily for 16 weeks	28 days supply	_____
☐ **Sovaldi®** (sofosbuvir)	☐ 400mg tablet	☐ Orally one time daily for 12 weeks ☐ Orally one time daily for 16 weeks ☐ Orally one time daily for 24 weeks	28 days supply	_____
☐ **Viekira XR®** (ombitasvir, paritaprevir, and ritonavir tablets, dasaburvir tablets)	☐ 200mg, 8.33 mg, 50 mg, and 33.33 mg extended release tablets	☐ Orally one PAK daily w/food for 12 weeks ☐ Orally one PAK daily w/food for 12 weeks	28 days supply	_____
☐ **EPCLUSA®** (sofosbuvir & valpatasvir)	☐ 400mg/100mg tablet	☐ Orally one time daily for 12 weeks	28 days supply	_____
☐ **Daklinza®** (daclatasvir)	☐ 30 mg tablet ☐ 90 mg dose ☐ 60 mg tablet	☐ Orally one time daily for 12 weeks ☐ Orally one time daily for 24 weeks	28 days supply	_____
☐ **Technivie ™** (ombitasvir, partaprevir, and ritonavir tablets)	☐ 12.5 mg, 75 mg, 50 mg tablets		28 days supply	_____

Physicians Signature: _____ Date: _____

I authorize The Honolulu Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.