

# Hepatitis C Referral Form



Phone: 808-533-8887  
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 E-Prescribing Available

Attention: \_\_\_\_\_ Need By Date: \_\_\_\_\_ First Ship To:  Patient  Physician

<b>Patient</b>	Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Address: _____ City: _____ State: _____ Zip: _____
	Home#: _____ Work #: _____ Cell#: _____ Best time to call: <input type="checkbox"/> AM <input type="checkbox"/> PM
	Soc. Sec #: _____ - _____ - _____ Ethnicity: _____ Primary Language: _____
	Comorbidities: _____ Height: _____ Weight: _____ Date: _____
	Allergies: _____ <input type="checkbox"/> NKDA

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

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

<b>Clinical Info</b>	Diagnosis/ICD-10: 318.2 HCV (chronic) other: _____ Genotype/Subtype: _____ / _____
	Patient type: <input type="checkbox"/> naïve <input type="checkbox"/> relapse <input type="checkbox"/> partial responder <input type="checkbox"/> null responder For genotype 1a, is the Q80K polymorphism present? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Cirrhosis: <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, is it: <input type="checkbox"/> compensated <input type="checkbox"/> decompensated Baseline Viral Load: _____ IU/ml
	Metavir score: <input type="checkbox"/> F0 <input type="checkbox"/> F1 <input type="checkbox"/> F2 <input type="checkbox"/> F3 <input type="checkbox"/> F4 Fibroscan™: _____ kPa FibroSURE®: _____
	Activity: <input type="checkbox"/> A0 <input type="checkbox"/> A1 <input type="checkbox"/> A2 <input type="checkbox"/> A3 Is patient awaiting liver transplantation for hepatocellular carcinoma?
	Child Pugh Score: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> Yes <input type="checkbox"/> No

## Prescription

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

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