

# 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Child Pugh Score: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C
	Is the patient interferon-intolerant? <input type="checkbox"/> Yes <input type="checkbox"/> No

## Prescription

Medication	Strength	Directions	Quantity	Refill
<input type="checkbox"/> Daklinza®	<input type="checkbox"/> 60 mg <input type="checkbox"/> 30 mg*	Take 1 tablet by mouth once daily with or without food <small>*30 mg dose is utilized when given in combination with strong CYP3A inhibitors. 90 mg dose is to be administered when given in combination with moderate inducers of CYP3A.</small>	28 days supply	_____
<input type="checkbox"/> Harvoni® <small>(ledipasvir/sofosbuvir)</small>	90 mg/400 mg	Take 1 tablet by mouth once daily with or without food	28 days supply	_____
<input type="checkbox"/> Sovaldi®	400 mg	Take 1 tablet by mouth once daily	28 days supply	_____
<input type="checkbox"/> Technivie™ <small>(ombitasvir, paritaprevir, ritonavir)</small>	12.5/75/50 mg	Take 2 tablets by mouth once daily in the morning with a meal	28 days supply	_____
<input type="checkbox"/> Viekira™ Pak <small>(ombitasvir, paritaprevir, ritonavir, dasaburvir)</small>	12.5/75/50/250 mg	Take 2 ombitasvir/ paritaprevir/ ritonavir tablets once daily (in the morning) and 1 dasaburvir tablet twice daily (morning and evening)	28 days supply	_____
<input type="checkbox"/> Pegasys® ProClick™ PFS Vial	<input type="checkbox"/> 180 mcg <input type="checkbox"/> 135 mcg <input type="checkbox"/> ProClick™ only	Inject 180 mcg Sub-Q once weekly Inject 135 mcg Sub-Q once weekly Other _____	28 days supply	_____
<input type="checkbox"/> Pegintron® Vial	<input type="checkbox"/> 50 mcg/0.5 ml <input type="checkbox"/> 80 mcg/0.5 ml <input type="checkbox"/> 120 mcg/0.5 ml <input type="checkbox"/> 150 mcg/0.5 ml	Inject _____ mcg* Sub-Q once weekly <small>* Dosed at 1.5 mcg/kg</small>	28 days supply	_____
<input type="checkbox"/> Moderiba™ Dose Pack <input type="checkbox"/> RibaPak® Dose Pack	<input type="checkbox"/> 600 mg/600 mg <input type="checkbox"/> 600mg/400mg	Take 600 mg by mouth in the morning and 400 mg by mouth in the evening Take 600 mg by mouth in the morning and 600 mg by mouth in the evening	28 days supply	_____
<input type="checkbox"/> Moderiba™ Tabs <input type="checkbox"/> Ribavirin/Ribasphere® <input type="checkbox"/> Capsule <input type="checkbox"/> Tablet	200mg	Other: _____	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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