ivira specialty pharmacy

# Hepatitis C Referral Form

Please fax completed referral form to ivira:
**(302) 499-8729**
Please contact office for questions:
(302) 499-8727

## PATIENT DEMOGRAPHICS:

PATIENT NAME: _____ PREFERRED CONTACT #: _____

DATE OF REFERRAL: _____ SECONDARY CONTACT #: _____

SOCIAL SECURITY NUMBER: _____ ADDRESS: _____

DATE OF BIRTH: _____ GENDER: ☐ F ☐ M CITY, STATE, ZIP: _____

## PRIMARY DIAGNOSIS: PLEASE PROVIDE ICD-IO CODE

☐ B18.2 - Chronic hepatitis C virus DIAGNOSIS DATE: _____

## PRIOR THERAPY: PLEASE PROVIDE MEDICATION HISTORY

PRIOR THERAPY (if any): _____ APPROX START DATE: _____ APPROX. END DATE: _____ REASON FOR DISCONTINUATION: _____

## REQUIRED DOCUMENTATION: PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS

☐ 1. INSURANCE CARD (Front & Back) ☐ 2. PATIENT DEMOGRAPHICS ☐ 3. H & P ☐ 4. MOST RECENT LABS

## CLINICAL INFORMATION:

GENOTYPE: ☐ 1A ☐ 1B ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

FIBROSIS SCORE: ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4

CIRRHOSIS: ☐ NONE ☐ COMPENSTATED ☐ DECOMPENSTATED

CHILD-PUGH: ☐ A ☐ B ☐ C

VIRAL LOAD: _____ DATE: _____

HIV CO-INFECTIONSY ☐ YES ☐ NO

HEP B CO-INFECTIONS?: ☐ YES ☐ NO

## MEDICATION SELECTION:

| MEDICATION | STRENGTH | DIRECTIONS | QTY | REFILLS |
|---|---|---|---|---|
| EPCLUSA® | 400/100 MG | ☐ TAKE 1 TABLET BY MOUTH DAILY, WITH OR WITHOUT FOOD | ☐ 28 | REFILLS:____ |
| HARVONI® | 90/400 MG | ☐ TAKE 1 TABLET BY MOUTH DAILY, WITH OR WITHOUT FOOD | ☐ 28 | REFILLS:____ |
| MAVYRET® | 100/40 MG | ☐ TAKE 3 TABLETS BY MOUTH ONCE DAILY WITH FOOD | ☐ 28 | REFILLS:____ |
| RIBAPAK® | ☐ 600 ☐ 800 ☐ 1000 ☐ 1200 | ☐ 200 MG PO QAM, 400 MG PO QPM ☐ 400 MG PO QAM, 400 MG PO QPM ☐ 600 MG PO QAM, 400 MG PO QPM ☐ 600 MG PO QAM, 600 MG PO QPM | ☐ 28 ☐ 28 | REFILLS:____ REFILLS:____ |
| MODERIBA® | ☐ 600 ☐ 800 ☐ 1000 ☐ 1200 | ☐ 200 MG PO QAM, 400 MG PO QPM ☐ 400 MG PO QAM, 400 MG PO QPM ☐ 600 MG PO QAM, 400 MG PO QPM ☐ 600 MG PO QAM, 600 MG PO QPM | ☐ 28 ☐ 28 | REFILLS:____ REFILLS:____ |
| RIBAVIRIN® | ☐ 600 ☐ 800 ☐ 1000 ☐ 1200 | ☐ 200 MG PO QAM, 400 MG PO QPM ☐ 400 MG PO QAM, 400 MG PO QPM ☐ 600 MG PO QAM, 400 MG PO QPM ☐ 600 MG PO QAM, 600 MG PO QPM | ☐ 28 ☐ 28 | REFILLS:____ REFILLS:____ |
| SOVALDI® | 400 MG | ☐ TAKE 1 TABLET BY MOUTH DAILY, WITH OR WITHOUT FOOD | ☐ 28 | REFILLS:____ |
| VOSEVI™ | 400/100/100 MG | ☐ TAKE 1 TABLET BY MOUTH DAILY WITH FOOD | ☐ 28 | REFILLS:____ |
| ZEPATIER™ | 50/100 MG | ☐ TAKE 1 TABLET BY MOUTH DAILY, WITH OR WITHOUT FOOD | ☐ 28 | REFILLS:____ |

## PRESCRIBER INFORMATION:

PHYSICIAN NAME: _____ PHONE: _____

OFFICE CONTACT: _____ FAX: _____

ADDRESS: _____ LICENSE #: _____

CITY, STATE, ZIP: _____ NPI: _____

PHYSICIAN SIGNATURE: _____ DATE: _____