

Add Logo

E-prescribe the *Fast & Easy* way: select **(Add company name)** from your EHR!

Fax: (000) 000-0000

Phone: (000) 000-0000

HCV REFERRAL FORM

PATIENT INFORMATION

Patient's Name:		SSN:		DOB:	
Address:		City:		State:	
Home Address:		Cell:		Height:	
				Weight:	
Email:				Gender: Male Female	
				Diagnosis Code:	

INSURANCE INFORMATION (or attach copy of the cards)

Primary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

CLINICAL INFORMATION (attached copy of labs)

Responder status: <input type="checkbox"/> Treatment Naïve <input type="checkbox"/> Treatment Experienced Prior Treatment Type: _____ _____ Did patient fail NS5A based treatment (Harvoni, Daklinza, Viekira, Zepatier)? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please include RAV)	Comorbidities: <input type="checkbox"/> ESRD <input type="checkbox"/> HIV <input type="checkbox"/> HBV <input type="checkbox"/> Diabetes <input type="checkbox"/> Other _____ Fibrosis Stage: _____ Child-PugScore: _____	HCV genotype: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 1a <input type="checkbox"/> 2a <input type="checkbox"/> 3a <input type="checkbox"/> 4a <input type="checkbox"/> 1b <input type="checkbox"/> 2b <input type="checkbox"/> 3b <input type="checkbox"/> 4b <input type="checkbox"/> Other _____ HCV RNA: _____ Cirrhosis: <input type="checkbox"/> Y <input type="checkbox"/> N If YES: <input type="checkbox"/> Compensated <input type="checkbox"/> Decompensated
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Test Type	GT1 NS5A RAV Test	Genotype + GT1a RAV (reflex) panel	Viral Load + GT1a RAV (reflex) panel	Viral Load + Genotype (reflex) + GT1a RAV (reflex) panel
Quest Lab	92447(X)	93871(X)	N/A	93873(X)
LabCorp	550325	550615	93873(X)	550705

PRESCRIPTION INFORMATION (for IV medication attach a copy of prescription)

MEDICATION	SIG/ DIRECTIONS:	QUANTITY	REFILLS
<input type="checkbox"/> EPCLUSA® (sofosbuvir 400 mg/ velpatasvir 100 mg)	One tablet taken by mouth once daily.	28 Day Supply	
<input type="checkbox"/> HARVONI® (ledipasvir 90 mg/ sofosbuvir 400 mg)	One tablet taken by mouth once daily.	28 Day Supply	
<input type="checkbox"/> MAVYRET™ (glecaprevir/ pibrentasvir)	Three tablets (total daily dose: glecaprevir 300 mg and pibrentasvir 120 mg) taken orally once daily with food.	28 Day Supply	
<input type="checkbox"/> RIBAVIRIN 200 mg	_____ mg AM _____ mg PM	28 Day Supply	
<input type="checkbox"/> VOSEVI™ (sofosbuvir 400 mg/ velpatasvir 100 mg/ voxilaprevir 100 mg)	One tablet taken by mouth once daily with food.	28 Day Supply	
<input type="checkbox"/> ZEPATIER® (elbasvir 50 mg/ grazoprevir 100 mg)	One tablet taken by mouth once daily.	28 Day Supply	
<input type="checkbox"/> Other			

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution.

 Dispense as written

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	
Address:	Ship To: <input type="checkbox"/> Patient <input type="checkbox"/> MD Office	
NPI #:	Tax ID#:	
Prescription Signature:	Date:	

Your signature authorizes (add company name) Pharmacy Services, LLC, and their network of pharmacies, to act on your behalf to obtain prior authorization, including appeals and peer to peer reviews, for the prescribed medications We will also pursue available copay and financial assistance on behalf of your patients. ©2023 CarepathRx. All rights reserved.