Across Specialty Pharmacy

HEPATITIS C REFERRAL FORM (A-L)

PH (770) 746 0130 | FAX (770) 746 0131
NCPDP 1175288 | NPI 1275142614

PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax	
Referral Contact Email	Office Phone	Office Fax	
Practice / Facility Name	Prescriber Name / Specialty		
Address	City	State	ZIP
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #

CLINICAL INFORMATION

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment ☐ Partial Responder ☐ Non-Responder ☐ Relapser Last Date of Therapy: Product Used:					Therapy Start Date
Anticipated Length of Therapy ☐ 8 weeks ☐ 12 weeks ☐ 16 weeks ☐ 24 weeks ☐ Other:			HCV Genotype ☐1a ☐1b ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐ No Cirrhosis ☐Compensated Cirrhosis ☐De-compensated Cirrhosis (CTP: ☐B ☐C)		
☐ Positive for Q80K Polymorphism ☐ NS5A Polymorphism ☐ Yes ☐ No ☐ NS5A Polymorphism Type ☐ M28 ☐ L31 ☐ Q30 ☐ Y93					
Fibrosis Score ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4			Baseline HCV RNA Viral Load (IU):		Date of Labwork:
Liver Biopsy ☐ Yes ☐ No Date of liver biopsy:	Results of liver biopsy:	ANC:	Draw Date:	Hgb:	Draw Date:
Coinfections ☐ HIV ☐ HBV ☐ Post-Transplant ☐ Pre-Transplant ☐ CKD ☐ Dialysis ☐ Other:					
PPI/HS Antagonist use During Treatment ☐ Yes ☐ No	Agent use:		Patient told to hold ☐ Yes ☐ No		
Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty:	Date Provided:		Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:
Other/Concomitant Medications (please list)					
Drug Allergies ☐ NKDA ☐ Yes (please list)			Other Allergies (please list)		
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)					
ICD-10 Code ☐B18.2 Chronic HCV ☐ Other:					

PRESCRIPTION INFORMATION

Medication	Dose / Strength	Dose Direction	Qty	Refills
☐ Epclusa Tablets	☐ 400 mg/100 mg ☐ 200 mg/50 mg	☐ Take one tablet by mouth once daily with or without food	28	
☐ Epclusa Packets *Pediatric patients 3 years & older Current Weight: _____ lbs / kgs*	☐ 200 mg/ 50 mg ☐ 150 mg/37.5 mg	**<17 kg:** ☐ Take one 150 mg/37.5 mg packet once daily **17 kg to Less than 30 kg:** ☐ Take one 200 mg/50 mg packet once daily **At least 30 kg:** ☐ Take two x 200 mg/50 mg packets (400 mg/100 mg) once daily *Do not chew. Can be taken directly in mouth or with food. Sprinkle on 1 or more spoonfuls of non-acidic soft food (e.g., pudding, ice cream) at or below room temperature. Take within 15 minutes of gently mixing & swallow entire contents.*	4 weeks	
☐ Harvoni Tablets	☐ 90 mg/400 mg ☐ 45 mg/200 mg	☐ Take one tablet by mouth once daily	28	
☐ Harvoni Packets	☐ 33.75 mg/150 mg	☐ Take one packet by mouth once daily	28	
	☐ 45 mg/200 mg	☐ Take one packet by mouth once daily ☐ Take two packets by mouth oncedaily *Do not chew pellets. May be sprinkled on 1 or more spoonfuls of non-acidic soft foods (e.g., pudding, mashed potatoes, ice cream) at or below room temperature; gently mix. Swallow entire contents within 30 minutes of mixing.*	28 56	
☐ ledipasvir-sofosbuvir Tablet (generic Harvoni)	☐ 90 mg/400 mg	☐ Take one tablet by mouth once daily	28	

By signing this form, you authorize Across Specialty Pharmacy and its representatives to serve as your designated agent in submitting clinical and other required information to third party payors with respect to this prescription and any refills or continuation of the same medication and dose for this patient as well as help the patient apply for co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

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Prescriber Signature _____ Date _____ Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____ Brand Necessary (must handwrite) _____

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HEPATITIS C REFERRAL FORM (M-Z)

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PATIENT INFORMATION

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Email	Home Phone	Work Phone	Cell Phone		
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Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐Email ☐Phone ☐Fax	
Referral Contact Email	Office Phone	Office Fax	
Practice / Facility Name	Prescriber Name / Specialty		
Address	City	State	ZIP
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #

CLINICAL INFORMATION

Patient New to Therapy ☐Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment ☐ Partial Responder ☐ Non-Responder ☐ Relapser Last Date of Therapy: Product Used:					Therapy Start Date
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☐ Positive for Q80K Polymorphism ☐ NS5A Polymorphism ☐ Yes ☐ No ☐ NS5A Polymorphism Type ☐ M28 ☐ L31 ☐ Q30 ☐ Y93					
Fibrosis Score ☐ F0 ☐ F1 ☐ F2 ☐ F3 ☐ F4			Baseline HCV RNA Viral Load (IU):		Date of Labwork:
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Coinfections ☐ HIV ☐ HBV ☐ Post-Transplant ☐ Pre-Transplant ☐ CKD ☐ Dialysis ☐ Other:					
PPI/HS Antagonist use During Treatment ☐ Yes ☐ No	Agent use:		Patient told to hold ☐ Yes ☐ No		
Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty:	Date Provided:		Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:
Other/Concomitant Medications (please list)					
Drug Allergies ☐ NKDA ☐ Yes (please list)			Other Allergies (please list)		
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)					
ICD-10 Code ☐ B18.2 Chronic HCV ☐ Other:					

PRESCRIPTION INFORMATION

Medication	Dose / Strength	Dose Direction	Qty	Refills
☐ Mavyret Tablets *45 kg & > or 12 years of age & older*	☐ 100 mg/40 mg	☐ Take three tablets by mouth once daily with food	84	
☐ Mavyret Packets *3 years of age & older* *Current Weight:* _____ *lbs / kg*	☐ 50 mg/20 mg	**Less than 20 kg:** ☐ Take 3 packets (150 mg/60 mg) by mouth once daily with food **20 kg to Less than 30 kg:** ☐ Take 4 packets (200 mg/80 mg) by mouth once daily with food **30 kg to Less than 45 kg:** ☐ Take 5 packets (250 mg/100 mg) by mouth once daily with food *Sprinkle pellets on small amount of food with low water content (e.g., peanut butter, thick jam, Greek yogurt); swallow within 15 minutes of preparation. Do not crush or chew.*	84 112 140	
☐ Vosevi	☐ 400 mg/100 mg/100 mg	☐ Take 1 tablet by mouth once daily with food	28	
☐ Zepatier	☐ 50 mg/100 mg	☐ Take one tablet by mouth once daily with or without food (Please include results of NS5A resistance testing for GT 1a above)	28	
☐ Ribavirin	☐ 200mg tablets ☐ 200mg capsules	☐ Take_____mg by mouth in the morning and take_____mg by mouth in the evening	4 weeks	
☐ Other				

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Prescriber Signature _____ Date _____ Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____ Brand Necessary (must handwrite) _____