

# Hepatology Referral Form



**QUALITY SPECIALTY PHARMACY**

Prescriber's Name: \_\_\_\_\_

DEA #: \_\_\_\_\_ NPI: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Office Contact: \_\_\_\_\_

Representative: \_\_\_\_\_

Date: \_\_\_\_\_ Needs by Date: \_\_\_\_\_

Language: \_\_\_\_\_

Ship to:  Patient  MD Office

PATIENT INFORMATION: Please complete the following or [send patient demographic sheet](#).

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  M  F

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate: \_\_\_\_\_ Email: \_\_\_\_\_

PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION

CLINICAL INFORMATION: Please send recent clinical notes, current medications, labs, and tests to expedite the Prior Authorization.

Diagnosis: \_\_\_\_\_ ICD-10: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs

HCV Genotype: \_\_\_\_\_ HCV RNA: \_\_\_\_\_ IU/mL Fibrosis Stage:  Compensated  Decompensated  HEP B  HIV

Q80K Polymorphism  Treatment Naive  Non-Responder  Partial Responder  Responder/Relapser NS5A Polymorphism:  Yes  No

Co-Infected Patient HIV RNA: \_\_\_\_\_ copies/mL CD4/T-Cell Count: \_\_\_\_\_ Alt: \_\_\_\_\_ WBC: \_\_\_\_\_ Hgb/Hct: \_\_\_\_\_

Previous Treatment: \_\_\_\_\_ Date(s) \_\_\_\_\_ Duration \_\_\_\_\_

All labs are required to proceed, if labs are missing Quality will proceed with ordering labs for the patient. (varies state by state) If you have a preferred laboratory notify your account manager.

Check box to opt out of lab assistance

PRESCRIPTION INFORMATION

Medication	Strength	Directions/SIG	Duration	Quantity	Refill
<b>Hepatitis C</b>					
<input type="checkbox"/> Daklinza	<input type="checkbox"/> 30 mg tab <input type="checkbox"/> 60 mg tab	<input type="checkbox"/> 30 mg daily <input type="checkbox"/> 60 mg daily <input type="checkbox"/> 90 mg daily (30 mg tab + 60 mg tab)	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks		
<input type="checkbox"/> Epclusa <small>(sofosbuvir/velpatasvir)</small>	DAW <input type="checkbox"/> 0 <input type="checkbox"/> 1 (400 mg/100 mg)	1 tab daily	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks	28	
<input type="checkbox"/> Harvoni <small>(ledipasvir/sofosbuvir)</small>	DAW <input type="checkbox"/> 0 <input type="checkbox"/> 1 (90-400 mg)	1 tab daily	<input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks	28	
<input type="checkbox"/> Mavyret	(100 mg/40 Mg)	Take 3 tablets once daily with food	<input type="checkbox"/> 8 weeks <input type="checkbox"/> 12 weeks <input type="checkbox"/> 16 weeks	84	
<input type="checkbox"/> Moderiba	(200-400 mg)	200 mg tab OAM, 400 mg tab OPM (600/day)		56	
	(400-400 mg)	400 mg tab OAM, 400 mg tab OPM (800/day)			
	(600-400 mg)	600 mg tab OAM, 400 mg tab OPM (1000/day)			
<input type="checkbox"/> Riba Pak	(600-600 mg)	600 mg tab OAM, 600 mg tab OPM (1200/day)			
<input type="checkbox"/> Ribavirin	<input type="checkbox"/> 200 mg tab <input type="checkbox"/> 200 mg cap				
<input type="checkbox"/> Sovaldi	(400 mg)	1 tab daily	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks	28	
<input type="checkbox"/> Vosevi	(400 mg/100 mg/ 100 mg)	1 tab daily	<input type="checkbox"/> 12 weeks	28	
<input type="checkbox"/> Viekira Pak	(12.5 mg/75 mg/50 mg/250 mg)	Take 2 pink tablets with 1 beige tablet every morning with food and take 1 beige tablet every evening with food.	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks	112	
<input type="checkbox"/> Viekira Pak XR	(200 mg/8.33 mg/50 mg/33.33 mg)	Take 3 tablets once daily with food	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 24 weeks	84	
<input type="checkbox"/> Zepatier	(50 mg/100 mg)	1 tab daily	<input type="checkbox"/> 12 weeks <input type="checkbox"/> 16 weeks	28	
	<input type="checkbox"/> NS5A required for GT 1a				

Hepatitis B

<input type="checkbox"/> Baraclude <small>(Entecavir)</small>	DAW <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 0.5 mg <input type="checkbox"/> 1 mg	1 tab daily		30	
<input type="checkbox"/> Epivir HBV	100 mg	1 tab daily		30	
<input type="checkbox"/> Hepsera	10 mg	1 tab daily		30	
<input type="checkbox"/> Tyzeka	600 mg	1 tab daily		30	
<input type="checkbox"/> Viread <small>(Tenofovir Disoproxil Fumarate)</small>	DAW <input type="checkbox"/> 0 <input type="checkbox"/> 1 300 mg	1 tab daily		30	
<input type="checkbox"/> Vemlidy	25 mg	1 tab daily		30	
Other:					

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Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*Prescription is VOID if the Number of drugs prescribed is NOT noted. \_\_\_\_\_  1  2  3

IMPORTANT NOTICE: This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the center at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitter material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.