Hepatitis C Referral Form

Date: _____

1.)Patient Information *(Please provide front and back copy of patient's prescription insurance card)*

Name:		Date of Birth:	Sex: ☐ M ☐ F	Height:	Weight: lbs
Address:	APT/STE:	City:	State:	Zip:	
Phone Number:		Alt. Phone Number:	SS#:		
Text Messages? ☐ Y ☐ N	**Ship to:** ☐ **Patient** ☐ **Provider**	E-Mail Address:			
Insurance Plan:	ID #:	Bin:	PCN:	RX Group:	

2.)Provider Information

Office Name:		Provider Name:		
Address:	APT/STE:	City:	State:	Zip:
Phone Number:		Fax Number:		
NPI:	Tax ID:	Provider Type: ◯ MD ◯ DO ◯ NP ◯ PA-C ◯ Other:		

3.)Clinical Information *(please fax all applicable office notes & labs)*

ICD-10: _____ Date of Diagnosis: _____
HCV (Chronic): Genotype _____ Date Tested: _____
*If Genotype 1A: Is Q80k polymorphism present? ☐**Yes** ☐**No**
*If Genotype 1A: Is NS5A resistance associated polymorphism present? ☐ **Yes** ☐**No**
Fibroscan Value: _____ kPa Fibroscan Date: _____
Allergies: _____

Treatment naïve: ☐**Yes** ☐**No**
Previously treated with Interferon: ☐**Yes** ☐**No** (☐**Relapsed**)
Cirrhosis:☐**Yes** ☐**No** (if yes: ☐**Compensanted** ☐**Decompensated**)
Metavir: ☐**F0** ☐**F1** ☐ **F2** ☐**F3** ☐**F4**
Metavir Tested Date: _____
Viral Load: _____ IU/mL Date Drawn: _____

4.)Medications

Medication	Strength(Mg)	Directions	Quantity	Refills
☐ **Daklinza**	30☐ 60☐	Take 1 tablet by mouth once daily	28 tablets	
☐ **Epclusa**	400/100	Take 1 tablet by mouth once daily	28 tablets	
☐ **Harvoni**	90/400	Take 1 tablet by mouth once daily	28 tablets	
☐ **Mavyret**	100/40	Take 3 tablets by mouth with food once daily	84 tablets	
☐ **Ribavirin**	200	Take _____ tablets by mouth twice daily		
☐ **Sovaldi**	400	Take 1 tablet by mouth once daily	28 tablets	
☐ **Vosevi**	400/100/100	Take 1 tablet by mouth with food once daily	28 tablets	
☐ **Zepatier**	50/100	Take 1 tablet by mouth once daily	28 tablets	

Additional Notes:

5.)Provider's Signature

_____ Substitution Permissible

_____ Dispense As Written